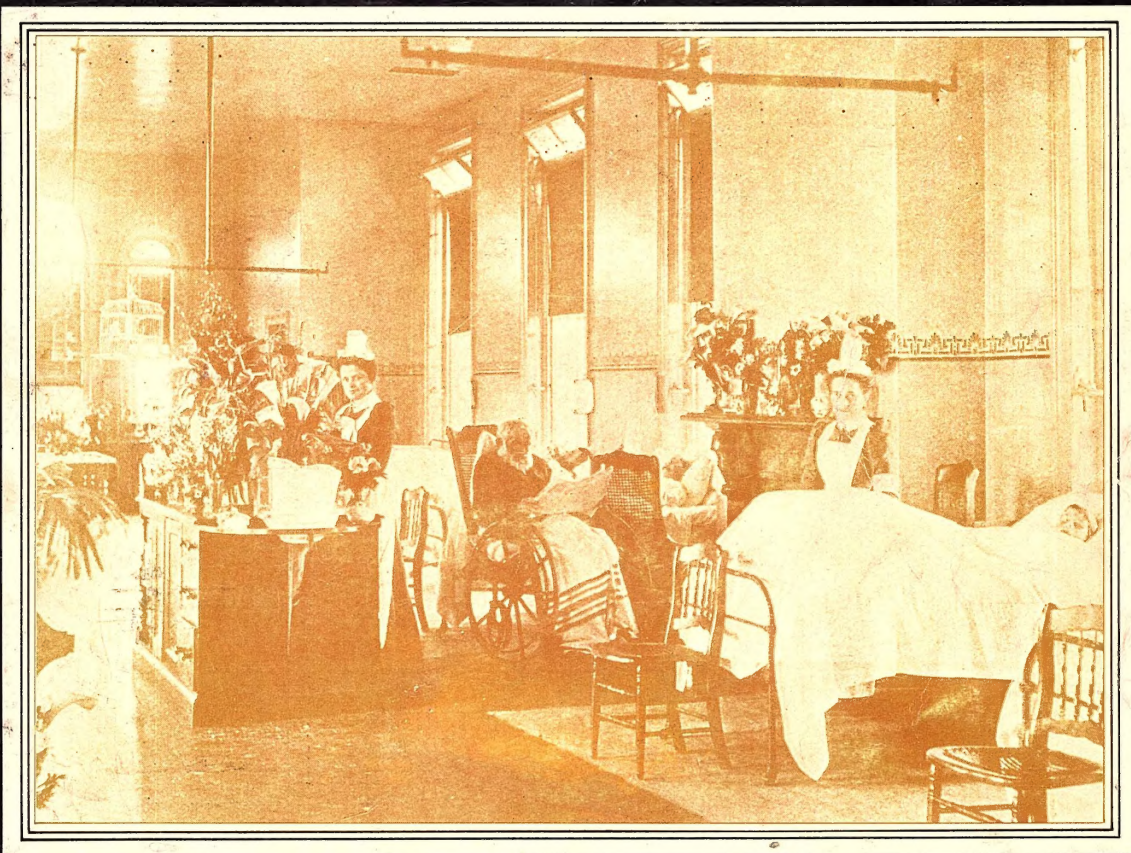


The Story of Auckland Hospital



1847 ~ 1977



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The Story of Auckland Hospital 1847~1977

David Scott ~ Editor

For the Medical Historical Library Committee of
The Royal Australasian College of Physicians
in New Zealand.

On the occasion of the celebration of
the opening of the main entrance of the new building
and a centenary of the opening of the old main building.
November, 1977.

Cover: Legend for cover picture, see page 21, fig. 13.

Inside Cover: Mr. Alan Wrightson, manager, Dr. Alex Warren, Medical superintendent and Miss Mary Wallis, principal nurse, at their weekly conference in the medical superintendent's office. They are examining the old leatherbound register of admissions and diagnoses, covering the years 1884 to 1893. The chest belonged to Dr. Thomas Philson, who was Dr. Warren's predecessor from 1859 to 1883.

Back Cover – An aerial view of the School of Medicine and the Auckland Hospital. The two partially completed buildings of the School of Medicine, which are lying closest to the camera, are the pre-clinical building extension on the left facing Park Road and the pathology and laboratory block on the right, with the crane alongside. The pre-clinical building, the link building, with its lecture theatres, and the clinical building are joined by glassed-in walkways at all floor levels. The new nurses' home on the corner of Grafton and Park Roads is clearly shown and the completed main block, with its new entrance. This present complex has developed over 130 years from the small cottage hospital standing in an empty field and situated within the L shape of the present Costley Block.

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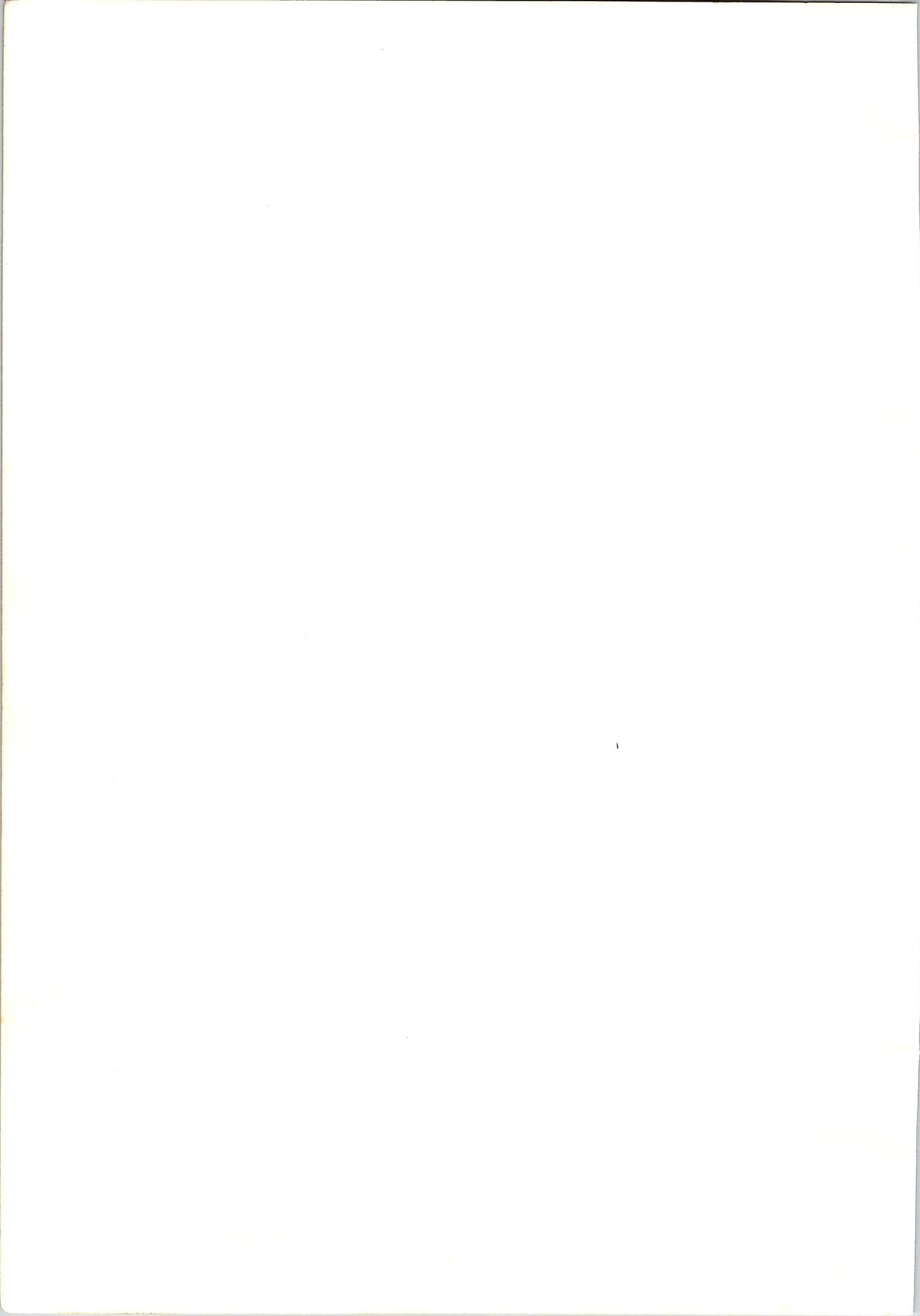
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FOREWORD

One hundred years after the first main building of Auckland Hospital was occupied, the second main building opens its doors. This new main building fulfils the dreams and plans of many people. The completion of one hundred years is a time both to celebrate and to reflect on the past, to gain insight for the future.

Our centennial celebrations 20-26th November comprise open days for health workers and for the public of Auckland, lectures by old staff members, two church services and two staff dinners.

For over a period of 130 years, the hospital has provided medical and nursing care to the citizens of Auckland. From a small colonial hospital in 1847, the institution has grown in size as Auckland has developed and the technical resources available to assist patient care have proliferated. The enthusiasm, dedication and foresight of medical, nursing and other professionals have kept the hospital's services abreast of the best developments.

The prescription of good quality health care combines the caring for patients with teaching and research. This, our predecessors worked and strove for. The fulfillment of their vision is the Auckland School of Medicine, closely related to the hospital.

Under the aegis of the Historical Library Committee of the Royal Australasian College of Physicians in New Zealand, staff, past and present, have contributed to this unique story of Auckland Hospital, recording facts with a leavening of the human endeavours which are its life.

A handwritten signature in cursive script, reading "A. D. Warren." The signature is written in dark ink and is positioned above the printed name of the Medical Superintendent.

Medical Superintendent

The word hospital in its modern sense had its derivation from roots related to the concept of host and guest and has affinities with hospice, hostel and hotel. This stress on board and lodging as opposed to medical care is a relic of the first organised provision, by religious orders, of accommodation for the old and destitute. Early references to hospitals in English literature suggests that the original hospitals were unhappy places.

Sir Thomas Browne (1605-1682) in *Religio Medici* wrote: —

"For the world, I count it not an inn but an hospital and a place, not to live, but to die in".

Thomas Southern (1660-1746) revealed the plight of the elderly: —

"And when we're worn,
Hack'd, hewn with constant service, thrown aside
To rust in peace and rot in hospitals".

A century later, Elizabeth Barrett Browning (1806-1861) suggested that there had been some improvement, at least in kindness, compared with the outside world: —

"I think it frets the saints in heaven to see
How many desolate creatures on the earth
Have learned the simple dues of fellowship
And social comfort in a hospital".

Hospitals as an integral part of the community developed in Great Britain in the 18th and 19th centuries. The first settlers in New Zealand were used to the idea of a hospital in each major centre of population and were determined that geographical isolation should not in any way preclude the benefits of civilisation. The first suggestion for the establishment of hospitals in New Zealand was made by Dr. Fitzgerald of Port Nicholson in *The New Zealand Gazette* of 16th May 1840. He saw the hospital not only benefiting the "fast increasing population" but also "the natives who certainly have a claim on the cause of humanity for it is truly deplorable to witness the frightful ravages disease has among them". In June 1840 a public meeting was called at Kororareka to discuss the establishment of a hospital. No action was forthcoming.

In March 1841 the seat of Government moved from Kororareka to Auckland. Between 1841 and 1845 many discussions took place in Auckland concerning the establishment of a hospital. Support came from the clergy,

including Bishop Selwyn, and from some of the Maori leaders. The stumbling block was the propriety of mixing native and European patients in the same wards. No progress was made until Lt. Governor Grey was appointed in November 1845. Grey's personal interest and his high standing with the Maoris were sufficient to overcome determined opposition. An article in *The New Zealander* on 11th April 1846 made a case for a "Maori hospital At very small expense, a building could be erected in Auckland, for a native hospital". Only a month later on 16th May 1846, the same paper published a report headed "General Hospital should be for all with a native ward We are much gratified to learn that the subject has received consideration and attention in higher quarters, — His Excellency the Governor, has, very humanely, intimated, that if the necessary funds can be arranged, he will grant a site, within the domain, near the Government garden, for the erection of the institution". By this time Governor Grey's message had been accepted: "However, it has been suggested, and we think with much judgement and humane feeling, that the benefits of the institution should not be exclusive; but, that exertion should, now, be made to found a sanitary establishment, for all persons of whatever nation or race". In 1846 the Government agreed to grant money for the erection of hospitals in Auckland, Wellington, Wanganui and Taranaki for the treatment of sick and destitute Europeans and the free treatment of all natives.

Tenders were called in Auckland in October 1846 and one was accepted in January 1847.

There is some evidence that there already existed both private and military hospitals in Auckland. A hospital was designed by Mr. F. Thatcher in 1846 for St. John's Theological College (Fig. 1). Dr. Arthur Guyon Purchas arrived as the first doctor in residence in mid-October 1846. *The New Zealander* of 26th September 1846 reported "a stone hospital of two storeys with accommodation for 40 patients, and with necessary offices, has been erected by the men of the 58th Regiment in a manner highly creditable to their industry and skill; the estimated expense of this building is £1300".

This was presumably near their barracks in Princes Street.

THE FIRST AUCKLAND HOSPITAL

The first hospital in Auckland was built, somewhat surprisingly, on the present site of the Auckland Hospital. Surprisingly, because Auckland was still a cluster of poor buildings and tents round the port and it was quite possible to get lost in the bush close to the town. The



Fig. 1. One of the first hospitals in Auckland was erected in 1846 at St. John's College at Tamaki. The hospital is on the extreme right of the group of buildings. Dr. Arthur Guyon Purchas, the resident surgeon, looked after patients and had his consulting room on the ground floor, while he and his wife lived in the upstairs storey. During his period at St. John's College he studied theology and was ordained in 1853. He later took charge of the parish of St. Peter's in Onehunga, a church he both designed and supervised as it was built. In addition to his dual professions of medicine and the ministry, he was an amateur geologist and an inventor and had a strong interest in church music. Though never on the staff of the Auckland Hospital, his son, his grandson, Edward Roche, and his great grandson, Anthony Roche, have all served at the hospital. The lithograph was made by Miss Cotton, from a drawing by Caroline Abraham.

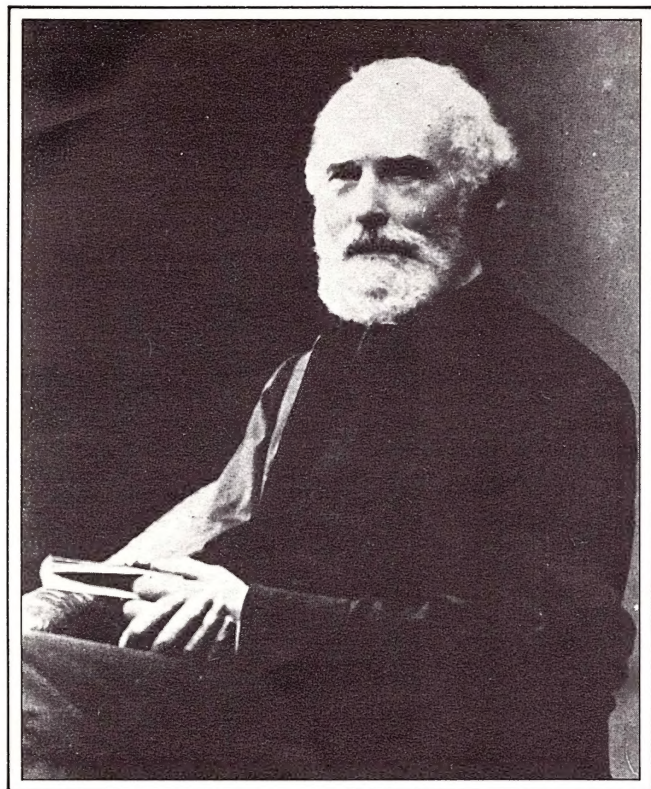


Fig.2. Frederick Thatcher (1814-1890), the architect of the first Auckland Hospital. Thatcher was born in Hastings, where his father was a riding officer, engaged in tracking smugglers on the Sussex coast. The family lived in a cottage alongside a medieval church. His early life in the shadow of this church may well have imbued the young boy with a love of church architecture. Details of his early training in Hastings are unknown. He was already a promising architect when he was 21 years of age and moved to London, where he was elected an associate of the Institute of British Architects, within a few months of arrival in the city. After seven years of practice he immigrated to New Zealand, landing in New Plymouth. One wonders whether the death of his wife after only a year of marriage, and a chance meeting with Bishop Selwyn in London, were among the factors that influenced him to immigrate. He was assistant secretary to Governor Grey at the time of designing the hospital. The study is taken of him as an older man.

choice of site (where the present Auckland Hospital Costley Wards now stand), was probably determined by the current fear of "fever" and the emphasis on ventilation as a healing influence.

The architect of the original hospital was Mr. Frederick Thatcher, first incumbent of St. Matthew's parish in 1853 (Fig. 2). After his arrival in New Zealand in 1843, his occupations included, in addition to architecture, wheat farming, auctioneering, dispatch carrying, the positions of Superintendent of Public Works, assistant secretary to Sir George Grey, and acting clerk of the Executive Council of New Ulster. His services as an architect were in constant demand, particularly by Bishop Selwyn. Some of the other buildings he designed were the colonial hospital in New Plymouth (1848) St. Mary's Church, Parnell (1860) and St. Paul's Church, Wellington (1866).

The hospital was of wood on a scoria foundation and contained four wards of ten beds and two wards of five beds (Fig. 3). There were three small rooms for staff, a surgery, a kitchen and loft. The building opened for the reception of patients in November 1847 when *The New Zealander* on 17th November announced that "the institution was sufficiently advanced to completion to open for the reception of patients" and that "already many had experienced the benefits of this establishment". The first resident staff consisted of a dispenser and male nurse, a male cook, one servant and a native messenger.

The first medical officer was Dr. John Johnson, described by Governor Grey as a gentleman "by education, manners and position in society qualified to gain the regard and esteem" of both natives and

Europeans. As an amateur artist, his sketches and water colours provide us with a record of what early Auckland was like. Dr. Johnson had been appointed the colonial surgeon in 1841 at a salary of thirteen shillings a day with 50 lodging allowance. He was granted £50 for medical supplies and he had an assistant, who received £27-7s-6d per year. He resided away from the hospital (Fig. 4) and retained his private practice but hospital patients claimed his first attention. European patients obtained admission by applying to the colonial secretary. Natives who presented themselves to the hospital were admitted without restriction. Seamen from ships were admitted but the majority of patients were those from the working classes whose "dissipated lives had rendered them destitute". "On admission patients were stripped of their dirty clothes, bathed in a wooden tub, if sufficient water was procurable and put to bed. A card was put over the bed with the name, age, tribe or country of the person". In the first year, Europeans and Maoris were nursed in separate wards but in 1848 no distinction was made, nor has it ever been made since.

Governor Grey, writing on this subject said, "Notwithstanding the doubts of some as to the practicability of the plan of nursing natives and Europeans in the same wards, it cannot be denied that it has been carried out as certified by the medical officers with perfect and satisfactory results". During 1848, 158 Maori patients coming from as far afield as Rotorua, Tauranga and Hokianga were nursed side by side with Europeans. Three hundred and seventy-six Maoris received outpatient treatment from the free dispensary. The returns for the week ending 1st April, 1848, record 21 native and eight European inpatients. The total expenditure for the year 1848 was £1,008.

The records of the early years of the hospital are scanty. Many of the early documents were burnt in the fire which destroyed Government House, or were lost in the ship *White Swan* which was wrecked when conveying the appurtenances of Government to Wellington, the new capital, in 1865.

Dr. Johnson died in 1848 and was succeeded by Dr. William Davies who had come to New Zealand attached to the 40th Regiment. In his first report to the Governor on 1st January 1849 Dr. Davies says:

"The hospital, a wooden building, erected in the Government Domain, in the year 1847, occupies, I think, a bad position, as during very dry weather, the well, which has been sunk to a great depth, is quite dry, and water has to be brought a considerable distance for hospital uses; therefore one of the most useful requisites in a hospital is, at a certain period of the year, wanting.

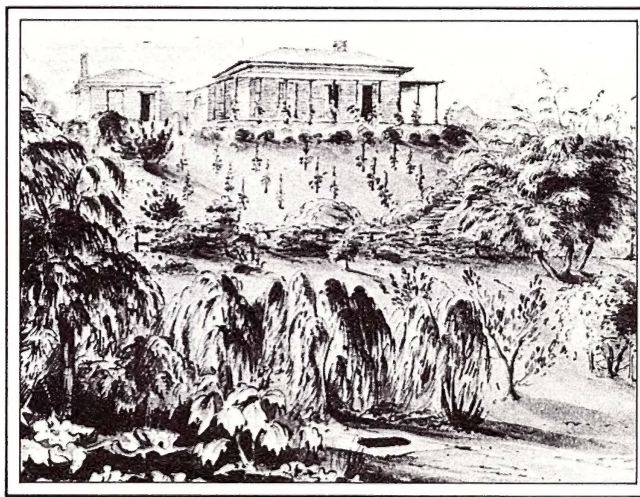


Fig. 4. A pen and wash drawing by Dr. John Johnson of his own home in Official Bay. The house would stand approximately where the present Railway Hotel is situated. He was a keen gardener and in 1843 had become the first president of the Auckland Agricultural and Horticultural Society. Some idea of his enthusiasm and achievement can be gauged from the inscription on the back of this drawing, "And the wilderness shall become the fruitful fields". What a far cry from the present slopes of Anzac Avenue.



Fig. 3. Charles Heaphy's sketch of the first Auckland Hospital, taken from the bottom of Grafton Road, where it intersects with Stanley Street. The near building is the female lunatic asylum, later known as the lower refuge. The hospital is at the top of what people called Hospital Hill. The choice of the site was probably dictated by a need to remove the contagious patients to a safe distance from town, and to make use of the strong winds on the hilltop to blow away the pestilence. One wonders if the authorities also had the vision to predict the growth of Auckland and to realise the healing effect of the grand vista the hill afforded.

The distance of the hospital from town is also, in my opinion, very much against its utility, as in several cases of fractured limbs, the patients have declared that they suffered great torture in being conveyed the great distance from town. The building itself, also, is in many respects defective and ill-adapted for the reception and treatment of persons labouring under diseases. The wind and rain find access into the different wards, and I have found this in many cases as almost insuperable barrier to the recovery of persons afflicted with lung diseases. At a very inconvenient distance from the house is a double water-closet and dead-house, we have no bath-house either for hot, cold, or vapour baths and the only means we have of making use of the warm bath to promote cleanliness and assist in removing disease is by employing a bathing tub of inconvenient size, in the wards of the hospital, the patients having to undress before others in the same ward. I find this extremely inconvenient with respect to the Aboriginal patients, and I would therefore recommend for the consideration of His Excellency, the priority of erecting a house to be used as a bath-house".

Apart from lining in 1849, the original hospital remained unchanged till 1859 when an additional wing was built, including a bathroom with boiler and furnace (Fig. 5). In 1855, Dr. Davies appealed to the Council for house accommodation at the hospital pointing out the expense and hardship he suffered at being almost completely separated from his family. He gave proof of the need for a medical man constantly in attendance. His appeal was unsuccessful and the following year he resigned. This lack of a residence within the hospital grounds was to plague successive medical officers till 1914.

In 1856 Dr. Thomas Francis McGauren was appointed provincial surgeon. Administrative responsibility for the hospital had passed from the Central Government to the Provincial Council in 1853. Dr. McGauren reported that the most prevalent diseases of the Europeans were "those of the heart, kidney and liver", and he expressed deep regret that the cause was "generally excessive indulgence of ardent spirits". The diseases most prevalent among the Maoris were of a "scrofulous or rheumatic nature". The failure of spread of

any contagious disease was "attributed to cleanliness together with the remarkably healthy situation of the hospital". In 1858 the provincial surgeon was given authority for the first time to admit urgent cases direct to hospital, instead of requiring the patient to apply to the Superintendent of the Province. The following year however, Dr. McGauren was asked to resign on a charge of incompetency. No investigations were allowed despite protests.

DR. PHILSON AND THE HOSPITAL

Dr. Thomas Moore Philson succeeded Dr. McGauren. Dr. Philson arrived in New Zealand in 1845 with the 58th Regiment. After six years he retired from the army and took up private practice in Auckland. At the time of his appointment in 1859 he was forty-two years old and he remained in charge of the original hospital as provincial surgeon till 1876 (Fig. 6). He was the senior medical officer of the second Auckland Hospital from 1877 till 1883. After 24 years' service he was appointed the first member of the honorary consulting staff in 1883. He died in 1899.

Dr. Philson was an outstanding medical figure in Auckland in the 1860s and 70s. In addition to the offices already mentioned, he held those of coroner, Port Health officer, Government adviser and medical officer to Fort Cautley, the jail and the lunatic asylum. His records, clinical and post-mortem summaries and his annual reports remain as the chief source of information about conditions in the original hospital till 1875. His regular complaints and outspoken comments between 1865 and 1875 must have had considerable influence in finally convincing the Provincial Government of the need for a new hospital in 1875.

Dr. Philson's first hospital case book, written in his own hand from 1st August, 1859, is held at Auckland Hospital (Fig. 7). His patients were, it seems, equally inured to hardship and to alcohol. "Native of Ireland" occurs regularly in these case reports and there is a frequent almost automatic addendum "addicted to drink". D.R. admitted on August 27, 1859, with delirium tremens was typical. "Was a draper for 12 years. Enlisted in service in 1855 in Her Majesty's 46th Regiment — served in the Crimea — left army in 1858 . . . states that



Fig. 5. The first Auckland Hospital taken some time after 1859, when the additional wing was built. This shows the northern aspect of the building. The main door to the hospital was on the southern side of the building. A fence and several outbuildings enclosed a courtyard. The influence of Frederick Thatcher's early architectural training in rural Sussex is apparent in this building. The white-washed base is of scoria. The framework is exposed and to its inner surface are nailed twelve inch wide kauri planks, which are battened on the outside. There is a shingled roof. With age and weathering, the gaps between these kauri planks widened and the wind whistled in. Note the leadlight windows. The new wing, though lacking the charm and proportion of the first hospital, was certainly more draught-proof and housed that essential amenity of the hospital, a bath.

he has had several attacks of delirium tremens previously". The treatment of a draught of opium frequently repeated plus gin 5 oz on admission was effective. Another patient "much addicted to drinking" was admitted with psoriasis but was subsequently attacked with influenza in his 4th week in hospital and died by asphyxia despite "brandy *ad libitum*".

The first Maori patient recored by Dr. Philson was admitted with quinsy on 15th August, 1859. The quinsy had already burst and the patient recovered in three weeks with purges and gargles as his only treatment. Special favour was shown in the prescription of extras — $\frac{1}{2}$ oz of tea, 2 oz. of sugar and 1 lb. of bread as well as a milk diet. Three days after admission a brief "omit extras" terminated such luxuries.

Dr. Philson's early industry in describing every case in detail was unfortunately short-lived. His case records of 1859 jump to his annual reports for 1865 and successive years until 1875. In these he gives a clinical summary, a detailed report of all deaths and postmortems and many glimpses of hospital life.

In his report for 1866 he tells of voluntary library services to the patients and adds: "Thanks are also due to the proprietors of *The Daily Southern Cross* and *Herald* newspapers who have gratuitously supplied the patients with their valuable journals". A later correspondent commenting on the selection of books suggested that "less of a theological element, and more of the light and cheerful class of literature, would be at once more interesting and, I think, more useful to the patients".

Under the heading of "Visitation" Dr. Philson in 1866 records three visits by "His Honor (sic) the late Superintendent", 48 by "ladies", 351 by clergy of various denominations, 58 by the general public, 111 by medical gentlemen and three by the Commissioner of Waste Lands! In 1865 there were further additions with initially a male ward and a few months later a second ward for females. The kitchen was enlarged and the collapsed morgue was replaced. The number of beds had reached 78 and the annual admissions were 695. The staff consisted of the provincial surgeon who was non-resident, a house surgeon, for the first time in that year, four male nurses, a matron and a cook. Patients were still admitted into hospital by application personally or by their friends to the office of the Superintendent of the Province in Princes

Street. In cases where there were funds a charge of 1s 6d per day was made. Already the hospital was overcrowded and 18 to 20 patients were obliged to sleep in the loft or on the dining room floor.

Dr. Philson was very reluctant to accept any responsibility for the collection of the fees from those who were able to pay. He was an extremely kindly and compassionate physician, and when taken to task in later years for allowing the hospital to become a rest-home for the indigent, he refused to concern himself with the patients' economic status. In the first 200 admissions that he recorded after his appointment in 1859 only 30 were listed as having to pay. After less than a year in office he ceased to make any entry in the column provided. By 1867 the average duration of stay of patients in hospital was 92 days and steps had to be taken to separate the sick from the indigent and elderly.

An interesting commentary on conditions in the hospital is contained in a letter to the Editor of *The Daily Southern Cross* on 30th June 1866: —

Sir, — Having been for several months a patient in this institution suffering from heart disease, and hearing so much lately about the sick and destitute, I have thought that a short description of the internal arrangements and management of that place may not be uninteresting to a few of your readers. The building, which is pleasantly situated, but badly adapted for the purpose, was erected about 19 years ago; since then two additions, on the east side, have been made to it — one about six years since, and another 18 months ago. There are seven wards — two on the west side appropriated to the females (of whom there are about 20), and five on the east side occupied by about 80 males. The female patients are attended to by a matron, and the males by a nurse and three assistants; this gives on an average one nurse to every 20 patients. In hospitals in England, I believe, there is a nurse to every 15 patients.

Every patient received daily 1 lb. of bread, 2 pints of tea, 1 pint soup, $\frac{3}{4}$ lb. beef, and 1 lb. of potatoes. Besides, extras are given to those who may require them, consisting of milk, eggs, sago, arrowroot, beef tea, mutton and fowl. The Head Nurse (Mr. Brown), who is very kind and attentive

to the patients, sees that everyone receives his proper diet. There is one article which I think ought to be added to the diet scale, viz, butter. I have seen many sick patients turn in disgust from their dry bread, that they might have taken had they been allowed a little butter. Miss Rye (who visited the hospital frequently before her departure for England) observed this, and sent a cask of butter at her own expense. In Melbourne Hospital (where I was six years ago with the same disease) every patient received butter; and I think, if our provincial executive cannot afford it to every patient, they ought at least to allow it as an extra, to be given to those that the surgeon may think proper.

In the Institution there are about paupers, under no medical treatment, classified as aged and infirm. Many of them are pensioners, hale, hearty men, in receipt of one shilling per day from the Home Government; and what with their rations, the food they get from the sick patients, and the extras they can afford to purchase, they live far superior to what our hard-working population can do in these dull times. I think it a great mistake to have these men crowding our hospital. I have heard cases where the sick had to apply more than once at the Superintendent's office before they received an order for admittance to hospital, owing to its crowded state. This should not be — either these paupers must be removed elsewhere, or a larger hospital will shortly be required. Now that the new Lunatic Asylum is finished, the present Lunatic Asylum might be turned into a Poor House, and indoor work of some description found for the inmates. Independent of this, I think that pensioners in receipt of seven shillings per week

ought, in justice, to provide their own lodgings (the Provincial Government supplying them with rations), instead of crowding an institution where every bed is required for our sick population.

The hospital is under the immediate superintendency of Dr. R. Fisher, House Surgeon, a gentleman of whom the least can be said is, that "he is the right man in the right place;" his kindness and attention to the patients is a "household word;" he visits the wards four times daily, and cheerfully answers any call by day or night, to alleviate the sufferings of the distressed. It is a pity that such a useful Public Servant should be so wretchedly underpaid. Last session the Provincial Government promised to increase the salary of the Provincial Surgeon as soon as the state of the Exchequer would allow them. I think at that time the claims of the House Surgeon ought not to be forgotten.

The institution is under the control of Dr. T.M. Philson, Provincial Surgeon, who is well known to the public of Auckland, and justly deserves the high encomiums recently passed upon him by several members of the Provincial Council. He attends daily from 9 a.m. to 12 noon, visits all the wards and examines all the patients. His residence is adjacent and he is at hand ready to attend in case of emergency. On the whole therefore I am able to say that the patients are well treated and well cared for, and that (with the exceptions I have named) the Auckland Provincial Hospital will bear favourable comparison with the noble institution in the sister colony. The institution is visited twice weekly or thrice weekly by the Church of England clergy. Service is held every Sunday before noon. The Roman Catholic clergy are also assiduous in their attendance to members of their flock, but I am sorry I cannot say the same of the ministers of the church of which I am a member, viz, the Presbyterian. Their visits are "like angels visits, few and far between". Bishop Selwyn has told me that the Church of England clergy consider it a part of their duty to visit the sick; possibly the ministers of the Presbyterian Church think differently.

Before concluding allow me to make an appeal to the public for donations of books for the library. Nearly all the patients, as soon as they are able to sit up in bed, or walk about, enquire for something to read. The library, which was established nearly ten years ago, needs replenishing; the books are tattered and worn out through constant usage. About six months ago Hunter Brown, Esquire, gave the valuable donation of 32 volumes. G.P. Pearce, Esquire, also sent *The Illustrated London News*, from October 1864 to February 1866. These gifts were valuable additions to the library; and I am sure there are many ladies and gentlemen, in Auckland, who would cheerfully give a few volumes, were they aware how eagerly the books are enquired after.

Dr. Fisher, House Surgeon (who takes a great interest in the library), will be glad, I am sure, to receive any such donation. I am and co,

Daniel McKay

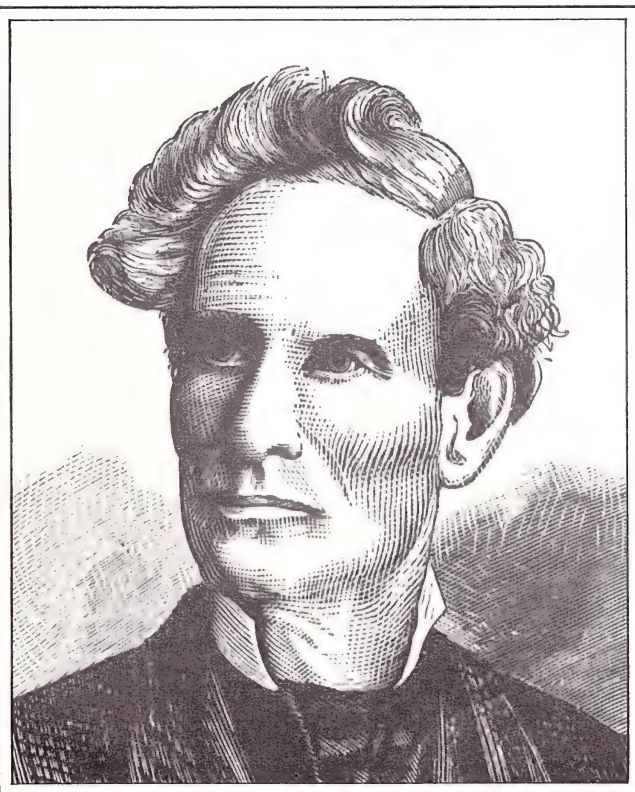


Fig. 6. Thomas Moore Philson (1817-1899). He was the eldest son of a mathematics master in Londonderry, Ireland. Entering Edinburgh University in 1834, he graduated M.D. in 1838. After assisting two general practitioners in Gloucester for a time, he joined the army, to be appointed assistant surgeon to the 58th Regiment, a unit which landed in the Bay of Islands in 1845. Later it moved to Wellington and then to Wanganui. In 1850 he resigned his commission and set up private practice in Auckland, where some of the descendants of his three sons and five daughters still live.

The etching shows him about the age of 42, when he took up his position as provincial surgeon. His face is full of character.

In 1866 Dr. Philson complained in his annual report; "There is urgent need of increased accommodation for female patients who are at present crowded into two small wards and a garret". He was distressed that he could not segregate the women, many of whom were "of the most degraded sort". Though only one in seven of the 716 admissions in that year were females, they appear to have upset Dr. Philson's Victorian sensibilities for he claimed that the unavoidable association of the young and virtuous with such patients "must be contaminating". He proposed that all the women be banished to the neighbouring asylum to leave the whole of the hospital to the males. Failing this he proposed partitions in the hospital passages and a separate entrance for each sex. The asylum to which Dr. Philson wished to remove the

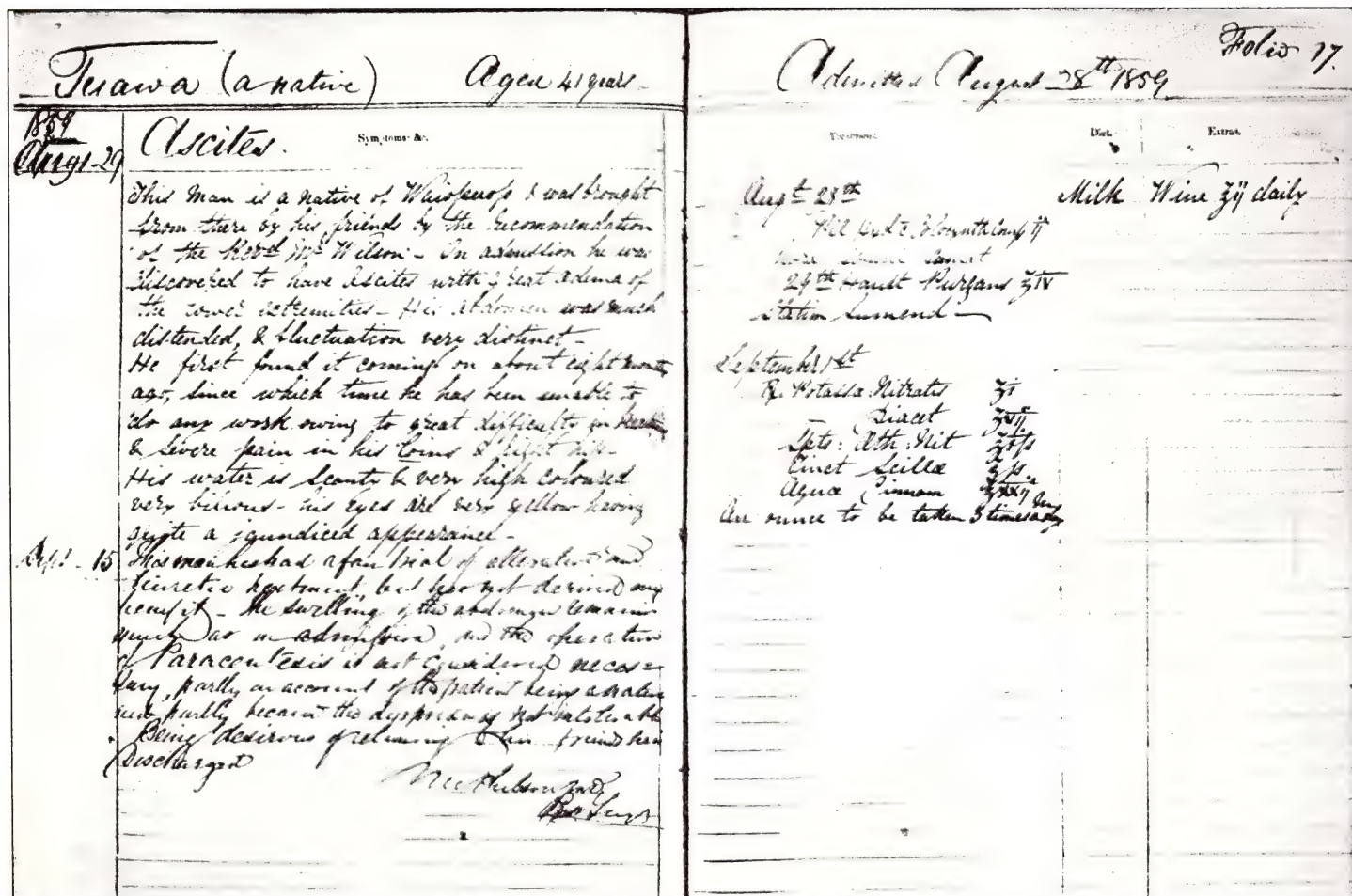


Fig. 7. Two pages from Dr. Philson's case book, recording the history and the findings of a Maori with jaundice, liver failure and ascites. In his note of the 15th of September, he justifies his decision not to drain off the abdominal fluid, and to let Tuawa return to his friends.

women was the first mental hospital in New Zealand (Fig. 8). It was built in 1851, with funds raised by public subscription, on a site just below the Auckland Hospital itself. It originally accommodated 11 patients till 1858 when an additional wing was built for females. Before these provisions, under the Lunatics Act of 1846, all mentally disturbed patients were committed to the jail which was a small and unsanitary building near the port. By 1862 the asylum was overcrowded and it was condemned as unsuitable for its purpose. The situation was relieved by the opening of a new asylum at Whau (the present Oakley Hospital) in 1867. Dr Philson wrote; "the new asylum is now ready for the reception of lunatics who will have the advantage of ample accommodation, suitable employment and enlightened medical supervision. It is needless to say anything about the old house which was only a makeshift — a prison. Henceforth thanks to the liberality of the province, justice will be done to the insane".

Despite Dr. Philson's description of "the old house", later called the lower refuge, it continued in service, as has often regrettably been the case with vacated inadequate accommodation since, for the old and destitute and for obstetric cases until it was deliberately destroyed by fire in 1890.

Inadequacy of water supply was one of the greatest problems in the original hospital. The only source was a well sunk when the hospital was built. Dr. Philson reported in 1865, "The hospital is in great need of constant supply of pure water. During the dry weather it was necessary to cart it from a distance at considerable expense". A small stream in the neighbouring reserve had been used to supplement the supply at first but this source was lost when building sections were sold. In 1866 Dr. Philson was delighted to report, "A great desideratum has been obtained in laying down water pipes from the reservoir to the asylum so that we now have a constant supply of water at all seasons. The work of carrying the water from the asylum to the hospital is performed by

convalescent patients".

Dr. Philson, in urging the replacement of the old hospital wrote in 1868; "With reference to the hospital itself it must be obvious to the most casual observer that the present building is only of a makeshift character and in many respects unworthy of the present advanced stage of the healing art, but it is vain to waste time in abusing the establishment when in spite of all its defects many have obtained signal benefit and which for many years was the only 'Bethesda' in the province". He wanted a hospital which would be a blessing to the sick and a credit instead of a reproach to the province. A correspondent in *The Southern Cross* described the hospital, "The whole is a sickly yellowish-whitish hue, covered with a half bleached shingled roof of a mottled blacky-white tint, with blared skylights, and you have the picture of a building, not pretty, but characteristic, and strongly suggestive of sickness and decay". Dr. Philson also felt that any plan which would exclude wind and rain from the wards would be a great blessing to the sick. The same correspondent agreed that the ventilation could not be "more thorough" with the air inside as pure as outside the building. He added; "perhaps it is questionable though if said ventilation can be sufficiently under control; and, however beneficial to those fractured limbs and to the success of the various efforts of surgery, it is doubtful, I think, that these poor sufferers, whose sunken cheeks and bright eyes and hectic flush tell of consumption slowly and silently mining within, would not be benefited by more graduated ventilation". The lighting of the original hospital by gas was the major improvement in 1871. Dr. Philson commented that "great satisfaction had attended this improvement on the old modes of illumination by sperm oil and kerosene".

The following year he reported that the most important incident was unquestionably the first appearance of smallpox in Auckland. With characteristic self-effacement he did not add that he had isolated himself with the affected patients in a "detached house in

the Hospital paddock" to help "prevent the communication and spreading of infection". Dr. Philson who had previously had smallpox, carefully outlined in his report the likely source of infection for each of those affected. The first patient was a seaman from the mail-steamer *Nebraska* who presented with a skin eruption and whose disease proved fatal. The only other death in the hospital was a man with chronic scrofulous, abscesses, though Dr. Philson could not explain how this patient had contracted the infection as he had had no communication with the first patient "direct or indirect". Other fatalities recorded included a fellow-lodger at the boarding-house in which the seaman had stayed prior to his admission, and the wife of the boarding-house keeper. Non-fatal infections were described in a waiter at the boarding-house, the infant of the hospital Matron and a carpenter, whose contact could be traced. All three had previously been vaccinated. After the outbreak had been successfully contained, the Superintendent of the province wrote to Dr. Philson expressing the very warm appreciation of the Provincial Government and enclosing a cheque of £100.

Before leaving the story of the original Auckland Hospital it is desirable to recapture some impression of the clinical problems of the day. Dr. Philson, essentially a physician rather than a surgeon, was aware of his therapeutic impotence and made painstaking observations of the gross pathology of the dead as a sort of penance for failure to sustain the living. Infectious diseases, usually lumped together under the title of "fever" were ill-understood for as yet there was no knowledge of bacteriology and even the idea of a new dimension of microscopic observation was outside the experience of the clinician. In his classification of admissions in 1867, Dr. Philson adopted Dr. Farr's nosology. There was a special grouping of "zymotic disease" or those that were "epidemic, endemic, communicable or inoculable". In this group were included "fever", typhoid, erysipelas, dysentery, venereal disease, worms and, surprisingly, scurvy. Scrofula, pulmonary consumption and meningitis were "constitutional", not communicable or infectious. Bronchitis, pneumonia, caries, abscesses and whitlows were "local". In 1870 the suggestion was made that the hospital was a dangerous place to enter because of hidden

dangers therein possibly related to inadequate ventilation. Dr. Pkhilson reacted hotly to this reflection on his hospital and to the suggestion that "morbid germs" or "Morbific sporules" could cause disease. "With much that has been said in favour of building a new hospital in keeping with the advancement of Auckland I fully agree but beg emphatically to deny that the walls of the present building are covered with 'morbid germs' and infested with the germs of pestilential disease. Hitherto we have had no such diseases to contend with but merely such as are to be met with in the most healthy place. And it may reasonably be doubted whether 'morbific sporules' are compatible with frequent white-washing with quick-lime. As regards ventilation our great evil in the old hospital is that we have too much of it for I must admit that some of the patients take cold from the draughts'. With a rare touch of humour he added; "We suffer from 'pores' rather than 'spores' ".

It is clear that the author of "Wanderings about Auckland: the General Hospital" in *The Southern Cross* 25th December 1869 did not share Dr. Philson's classification. Describing a visit to the hospital he wrote:

"Here, as in the jail and lunatic asylum, it is vain of course to speak of classification. Space is wanting, and classification is impossible. Who would defend the position of a poor fever-stricken patient, subject now to the delirium, now to the frustration, of typhoid fever, laid on that bed in the midst of a score of sufferers with broken limbs, consumption, and paralysis? What layman, leaving doctors to differ as they like as to the contagious or infectious nature of typhoid fever, would like to lay his broken limb on the adjoining bed, and sleep night after night surrounded by those fever emanations? Fever may not be infectious; there is a very popular impression that they are; and granted that it is but an ignorant imagination, we all know the patient inference of imagination in conveying mortal sickness; and I have no hesitation in asserting that the provincial authorities who have the oversight of the hospital, and whose neglect necessitates the placing of deadly typhoid fever among the beds of ordinary patients, are morally guilty for the consequences, and that public opinion should be

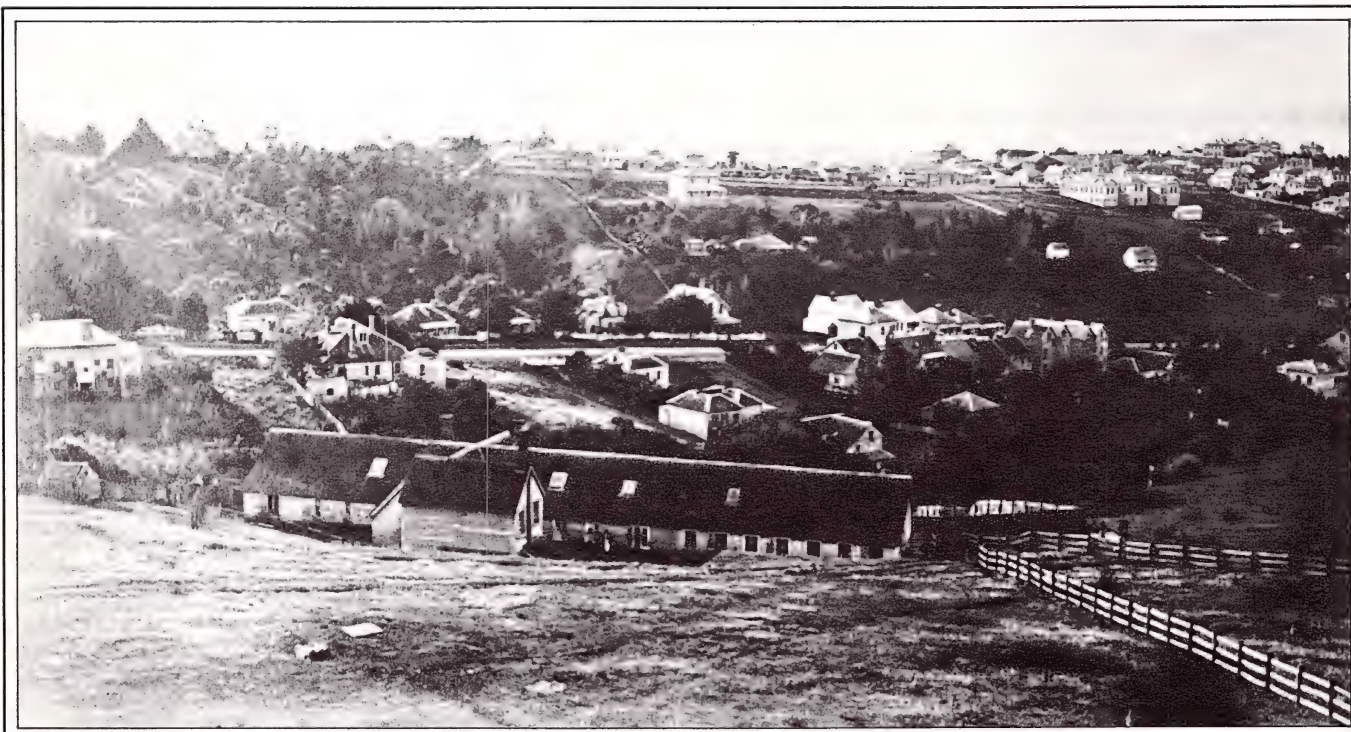


Fig. 8. The lower refuge some time before 1890. Grafton Road is in the middle ground and beyond Grafton Gully is Symonds Street. The first Auckland Grammar School (built in 1869) is the prominent building with three wings. The second St. Paul's Church has not yet been built. Erected in 1851, the lower refuge functioned first as a female lunatic asylum. When the new asylum at Whau, near Avondale, was completed in 1867, these patients were transferred to make way for the aged and infirmed patients of the Auckland Hospital. In 1890 these patients in turn moved to the Costley Home on the Green Lane Hospital site, and the lower refuge was deliberately destroyed by fire.

brought to bear in the strongest form to necessitate the erection of a proper and separate fever hospital".

The complete absence of any knowledge of cause was in contrast to the accuracy of clinical observation of effect which had permitted the differentiation of types of "fever". Typhoid was prevalent and its clinical features were accurately described by Dr. Philson. He recognised the adverse prognostic significance of muttering delirium and, in noting the frequency of terminal perforation of the bowel he stressed the danger of purgatives and the necessity for a low residue diet. He was an ardent supporter of Robert Graves, the Dublin physician, who had desired that his epitaph should be; "He fed fevers". Dr. Philson advised cordials (mainly alcohol) and a supporting regimen — milk and beef-tea day and night, with opiates, astringents and turpentine fomentations for diarrhoea. The mortality rate for his typhoid patients was 10 per cent.

There are two further reports which indicate how puzzled he was about the cause of "fever" in spite of his reluctance to accept the possibility of any agent invisible to the eye. In 1864, Dr. Philson was asked by the Government to report on the state of health of Auckland. The request arose following a difference of opinion between Sir George Grey and the Government on the disposal of nearly 200 Maori prisoners who were incarcerated in the coal-hulk *Marion* in the harbour. These prisoners had been captured in the battle of Rangiriri in 1863 and they were eventually confined in shocking conditions from 24th December, 1863, till 12th April, 1865. When sickness broke out among them in 1864, it became politically desirable to establish that health and hygiene in the hulk *Marion* were no worse than in the rest of Auckland generally.

Dr. Philson's report must be one of the strangest that has ever been rendered to a government. "I am unable to account for the increasing prevalence of fever although something is due to the increasing population, to the hardships and exposures of the present war. I think we shall look in vain for the second causes such as defective drainage, overcrowding, want of fresh vegetables, etc. The true cause you will find in the 90th Psalm, 8th verse... 'For we are consumed by thine anger and by thy wrath (due to us for sin) are we troubled'. And as to the remedy repentance toward God, and faith in Jesus Christ issuing in general reformation will prove a never failing specific".

His moral rearmament did not prevail with the Government or ensure the release of the prisoners but this report probably indicates Dr. Philson's strong personal disapproval of the whole affair. One of his duties as provincial surgeon was the care of the prisoners in Mt. Eden Jail and it is apparent from his annual reports that he treated them all with the utmost consideration.

The problem of causation of "fever" was still troubling Dr. Philson in 1875 when the new Auckland Hospital was under construction. Typhoid fever was even more prevalent and he commented, "The existing cause of the disease is very difficult to be ascertained. Some attribute it to drinking water contaminated with sewage but something more must be required. The cause will be obviated shortly in the city by the supply of pure water".

The "something more" was not to be revealed till 1880 when Eberth discovered the bacterium that bears his name... *Eberthella typhosa*, so preparing the way for Gaffky to prepare a pure culture of the organism in 1884, and to establish the bacterial and infective nature of "fever" including typhoid.

With the building of the new Auckland Hospital,

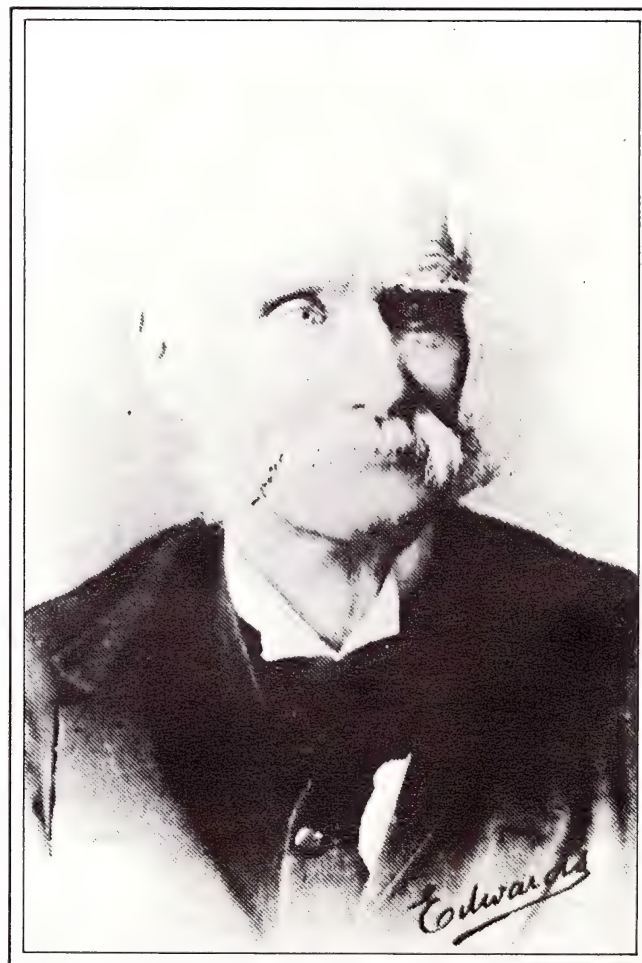


Fig. 9. Dr. Philson as an old man. The precise date of this photograph is uncertain. Written in his face are the experience and the tribulations of 24 years of running a hospital on a shoestring, coping with illnesses for which he had no cure and offering shelter and care to all.

the first hospital became the upper refuge, housing mainly the old and infirm till it was deliberately burned in 1890.

The history of the first Auckland Hospital is inseparable from the name of Thomas Moore Philson M.D., M.R.C.S. He survived the building of the new Auckland Hospital in 1877, though failing in health and eventually retired in 1883 with serious incapacity of his right hand, resulting from his fourth attack of septic poisoning acquired in the course of surgical practice (Fig. 9). That his retirement was preceded by some controversy concerning his surgical abilities in no way detracts from his contribution.

There is a *New Zealand Herald* report of a presentation to Dr. Philson in 1883 by the Mayor of Auckland, J.M. Clarke Esquire. In the name of 667 subscribers among the citizens of Auckland the Mayor presented a complimentary testimonial which was "most tastefully illuminated", a "handsome gold chronometer and chain" valued at over £100, a silver card case for Mrs. Philson and a purse of 270 sovereigns. Dr. Philson replied, "May it please Your Worship, I occupy this day a position at once trying and gratifying; trying because I feel out of place when I am called upon to appear in public, and truly I would have shrunk from the ordeal but that I could not so ill-requite your great kindness, as to allow myself to be influenced by natural sensitiveness on so important an occasion as the present". After expressing his thanks he went on, "The money accompanying these presents I propose, with your concurrence, to devote to the formation of a nucleus of a medical library for the use of the medical school, which, I hope will soon be inaugurated in connection with the Auckland Hospital". The suggestion that the library be called the Philson Library was greeted with applause though Dr. Philson

seemed reluctant to agree. Mr. Russell silenced his objections by saying "Dr. Philson has planted the seed and the tree should be called after him". The germination period of that seed was 85 years.

For 24 years, Thomas Philson laboured at the Auckland Hospital, caring for all and sundry and giving to the poor the same patient consideration he accorded dignitaries. He chose to work under these conditions rather than have the satisfaction of a private practice among the influential and wealthy members of the community. He was a true Christian gentleman and must have been a wonderful example to the young colony, whose members were striving for comfortable material conditions of life and who were harshly critical of those who had fallen by the wayside. His response to the needs of his fellow human beings was immediate and full without thought for his own safety or comfort. We had the old main building as a result of his untiring efforts and we now have a fine library bearing his name and a marble memorial tablet. However, his real legacy to this hospital and its successive generations of staff is his example of loving care.

When saw we thee a stranger and took thee in?
or naked and clothed thee?
Or when saw we thee sick, or in prison, and
came unto thee?
And the King shall answer and say unto them,
Verily I say unto you, Inasmuch as ye
have done it unto one of the least of
these my brethren, You have done it
unto me.

— Matthew 25 v38-40.



THE OLD MAIN BUILDING 1877-1964

a perspective of the period

David Scott

During this period generations of staff members and patients have gazed out of the windows and drawn inspiration from the view across the burnished waters of the inner harbour, beyond the near and distant islands to the majestic backdrop of the Coromandel Range. Mighty Moehau and the Great and Little Barriers are visible, forming bastions to the entrance of the Hauraki Gulf. Out of the young colony's first acclimatization station the sweeping parkland and the noble trees of the Auckland Domain have developed. Over the period the gracious grounds of the hospital have given way to a motley collection of 51 buildings of all sorts of architectural styles, sizes and modes of construction, strewn over the 17 acre site. Only a handful have been demolished. Although this confusion is disturbing and the precincts of the hospital no longer match the nobility of the Domain, the stories of these buildings and the reason for their construction and continued use is the fabric of our history.

A constant need to expand, persistent budgetary limitations, a tendency to *ad hoc* planning to meet real and imagined needs, such as epidemics, and the quirks of men are among the reasons for this conglomerate. The miracle of the hospital is that throughout this period of 87 years that it served the public of Auckland, the old main building and its satellites did function as an integrated whole. Antiquated buildings were made to work by concerned staff members, who gave generations of Aucklanders relief and comfort and support during their illnesses.

At the beginning of the era, the cottage hospital was a charitable institution, looking after seamen, Maoris and indigent white people, while the majority of settlers preferred to be nursed, give birth to their babies and die in the secure and familiar surroundings of their own homes. This is not surprising, because the hospital provided bare custodial care, few specific remedies and only rudimentary nursing. Alcoholism was a common problem and the raving of men in delirium tremens, as their brains adjusted to the declining alcohol levels, dominated the cottage hospital and its brand new successor. Despite the commissioning of the new building in 1877, conditions for the patients and the quality of nursing care did not substantially improve until 1883. In that year the first inspector of hospitals visited the institution to write a blistering report. Nurse Crisp, the first professional woman trained under the Nightingale system, was appointed and Dr Mackellar picked up the reins from the aging Dr. Philson.

Over succeeding years increasing competence in nursing care, a growth in the number of nursing and medical staff members and a slowly mounting medical knowledge, as well as the proper segregation of patients, all contributed to the improved lot of the sick person in Auckland Hospital. Lister's discoveries as regards aseptic techniques, led to a sudden mushrooming of surgery at the end of this century. The germ theory of infectious diseases resulted in practical isolation methods to barrier contagious patients. The growth of medical knowledge and pharmaceuticals quickened from 1930, each decade yielding an exponential increase in medical knowledge. By the end of the period a sophisticated technology was coming to occupy an essential place in the diagnosis and treatment of disease. Specialisation and super-specialisation added a depth of inquiry into specific diseases.

As hospital care became increasingly sophisticated, so have the standards of home nursing declined. There is reluctance for the family to nurse their sick members at home, particularly the frail elderly. So the Auckland Hospital and its daughter institutions have become the major refuge for seriously ill and dying patients, as well as those waifs of society without family, who formed the only patients in the first hospital.

During World War II the number of medical and nursing staff available to run the hospital was reduced,

because of the large contingent caring for our troops overseas. Those who stayed behind did a splendid job, both in the Auckland Hospital and in makeshift hospitals situated at the Ellerslie Racecourse.

The post-War years were a time of great change. The acquisition of Middlemore Hospital and setting up of the Cornwall Geriatric and National Women's Hospitals and the quickening growth of the Green Lane Hospital necessitated a reorganization of the Hospital Board with the appointment of Selwyn Kendrick, the first medical-superintendent-in-chief, and Wynne Delugar as his nursing counterpart. During their time at the Board many innovations were made, which facilitated the relationship between the medical and nursing professions in the hospital and the Board. These other hospitals eased the over-crowding on Auckland Hospital and took away patients with tuberculosis and a variety of respiratory diseases and those requiring cardiothoracic surgery to Green Lane. Middlemore took the orthopaedic problems and those requiring plastic surgery, as well as coping with some of the medicine and general surgery in the South Auckland district. National Women's Hospital enabled the transfer of obstetrics and gynaecology from Auckland, while the Cornwall Geriatric Hospital accepted the long-stay geriatric patients, which had been a considerable factor in the overcrowding. Although this meant a restriction in the range of specialities available in Auckland, it did much to ease the over-crowding. The Auckland Hospital staff for a brief period had pangs of envy, as they saw the tempo of development of these new hospitals. In the minds of some there was a fear that Auckland Hospital would be relegated, because of its over-crowded site and antiquated buildings.

Postgraduate educational activity and the vigour of the new specialties and an increasing determination to establish a medical school alongside the Auckland Hospital gave the staff new hope. Undergraduate education of sixth year medical students from Dunedin had begun in 1927 and their instruction was providing an interest and an experience in undergraduate education and a group of the medical staff destined to play important roles in the development of the medical school.

As with the first Auckland Hospital, where Maoris formed a substantial proportion of the patients treated, the late 1940s found the hospital again taking on a Polynesian character. The flooding of the rural Maoris to the inner city and the Island people immigrating from the Pacific to Grey Lynn and Ponsonby were substantial population movements. Polynesians became the majority of the domestic staff, both in the kitchen and among the cleaners, with smaller numbers among the nurses. In the Casualty Department and many of the wards, Polynesian patients, with their special problems, began to predominate. The staff had to work out new ways of providing for their care.



In Dr. Philson's annual reports from 1865 onwards, and in the daily newspapers, there were regular references to the inadequacy of the old hospital building and the asylum, both as buildings and as regards their total accommodation. The old hospital had an exposed framework, the walls being 12 inch wide kauri planks nailed vertically to the inside surface of the frame. The gaps were covered with exterior battens. With age and weathering, the gaps between planks widened and the cold southwest winds and the northeast gales whistled in, especially where the battens did not fit snugly. From 1865 onwards every night saw 18-20 patients sleeping on the floor of the dining room and in the lofts. The needs of the burgeoning town had outstripped the cottage hospital, which was becoming increasingly dilapidated and unsatisfactory. In the 1870s the need for new facilities became more and more apparent. A building contractor, John Taylor, was in the forefront of community agitation for a new and substantial building. In 1874 the Provincial Government resolved that it would no longer add piecemeal to the old hospital, but construct a large and entirely new building on the brow of the hill, overlooking the old hospital.

Philip Herepath wins the competition for the design of the second hospital.

The new site selected for the hospital meant encroaching on the Auckland Domain, the first of many successful attempts to augment the hospital land from that source. The Superintendent of the Province offered the sum of £50. Of the fourteen entries submitted, the design with Fido as the motto was selected. It proved to be Philip Herepath, one of the four leading architects in Auckland. He was already the architect of the Provincial Buildings' Commissioners. Some of the other buildings he designed in this decade were the school in Wellesley Street East, the St. Mark's Anglican Church in Remuera, the Congregational Church in Beresford Street (now St. James Church), the Fountain of Friendship Lodge, the

Museum for the Auckland Institute, Wesleyan Churches in Onehunga and Pukekohe, as well as breweries, shops, factories and private residences.

With such a large and specialised building, it was natural for Philip Herepath to turn to the old country for guidance and inspiration, considering that a tradition of major hospital building had begun to evolve there over the previous 50 years. He had recourse to the plans of the Bedlam Hospital for general layout. He adopted a modern ventilation system based on that of the Herbert Hospital in Woolwich and St. Thomas's Hospital in London. It was reasonable to assume that these three buildings would represent the latest in English hospital design.

The design of the new building and its shortcomings. (Fig. 10).

The plan showed a noble building in the Italian style. In that country it could have been the country residence of a nobleman, with the upper two floors accommodating the family, while the ground floor housed the servants, kitchen and storerooms. The building was 226 feet long and 71 feet wide, made up of a basement and three storeys. The broad aspect of the building faced north, and on this facade each storey had a long 8ft. wide open balcony. Exterior staircases on the north and south facades gave access to the first floor, while an interior staircase, 12 feet wide linked the first and second floors. While there was provision for a lift, this was not installed until 1909. The external stairs were steep, with narrow treads. Each stretcher case had to be carried in all weathers up these stairs. They were an additional hazard to convalescent patients and visiting relatives. Their mass shaded the central portion of the ground floor, making it ill-lit and poorly ventilated. The fire risks of these arrangements don't bear thinking of.

The modern features of the design were the ventilation, chutes for soiled linen and dust leading from each ward to the basement and the grouping of lavatories, bathrooms and washing facilities in towers situated at



Fig. 10. The Auckland Hospital in 1883. This early photograph shows the main building set in an unkempt field. On the balcony outside Ward 3 are some of the 88 men who resided in the hospital. A large proportion of these were men, burnt out by the ravages of disease and an intemperate life. The whole building had an air of desolation, which was to be transformed within a few months, when Dr. Mackellar and Nurse Crisp joined its staff.

Philip Herepath's Auckland Hospital is a building of quiet distinction, having features more suggestive of a European rather than an English influence. In its time it incorporated the latest features of hospital ventilation, whereby the air entered a narrow top segment of the casement windows. Effluent air was collected and ducted to the roof, entering the octagonal campanile on the top of the building, escaping through louvred openings. The towers at each end contained the lavatories, bathrooms and washing facilities for the wards. In 1908 replacement towers with these facilities were fitted on the south facade, and these old towers were converted into rooms housing one or two patients.

each corner of the building. The four principal wards occupied the wings of the upper two storeys. Each was 75 x 26ft., with 14½ft. high ceiling, so as to give each of the 24 patients over 1,000 cubic feet of air space. Air was supposed to come in narrow hinged windows situated at the top of the usual casement windows. Effluent air from the wards was collected and ducted to a louvred octagonal campanile situated in the centre of the roof, with a flag pole set on top of it.

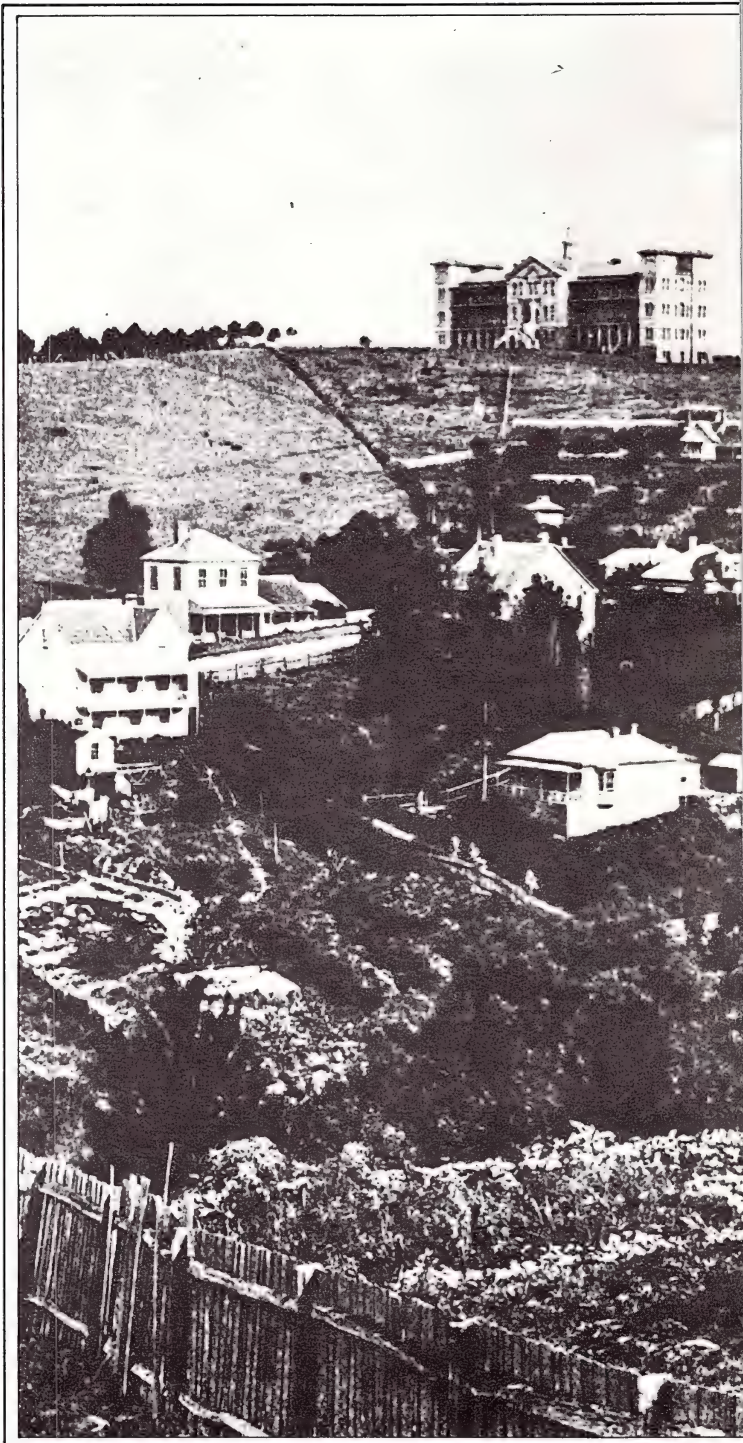
The central area of the top floor was occupied by a fever ward, and the bedrooms of the matron and her two or three nurses. On the first floor there was the boardroom, library, accident ward and an operating theatre, as well as a second fever ward in the central portion. The ground floor comprised the kitchen, the dining room for convalescent patients, reception room, two rooms for the medical officer, several private wards, a storeroom and a dispensary. Wine cellars, the mortuary and a 3h.p. steam engine for pumping water from the 70ft. well, were all accommodated in the basement. The water was stored in three cisterns in the top of the building, giving together 10,000 gallons storage.

The shortcomings of the design became only too apparent with use. The siting of the towers gave a noble proportion to the building and acted as buttresses at each end, but it did mean that generations of nurses and patients were condemned to walk the entire length of the ward many times a day to prepare a dressing, store soiled linen, go to the lavatory or have a bath. Replacement towers with washing facilities were added in 1908, and these were more conveniently situated halfway along the wings on the south facade. The placing of the fever wards in the central portion of the top two storeys gave them common access with the ordinary wards. Each time the entrance door on the first floor was opened, a blast of air pumped germ-laden dust particles from these fever wards into the ordinary wards, often with disastrous results. The special consideration for ventilation, given in the design of the building, did not prove successful, because the wards were draughty places, especially when the doors were opened. On the ground floor ventilation, or lack of it, was such that the stench of the morgue issuing from the trap door, situated near the kitchen, mingled with the cooking odours. This access to the morgue merits description. Underneath the trap door was a inclined tramway, so that the stretcher with its cadaver could be lowered on to a little trolley and trundled down to the morgue on its own. Dr. Grabham, in his report, referred to the mortuary tramway as *facilis descensus Avern* — the easy descent to Hell.

I have mentioned only a few shortcomings of this design. Some were remedied in the first 20 years, but others were never put right in the life of the building. One would have thought the clear-sighted, pragmatic settlers would have vetted the design with practical considerations uppermost in their minds. However, there was no practical experience in hospital design in the young town or in European countries for that matter. One suspects that aesthetic considerations were the main yardstick guiding the selection of the design. Civic pride was satisfied by the building, although the access and internal arrangements enslaved generations of nursing staff.

Construction of the building.

The contract price of £19,249 submitted by John Taylor Esq., was accepted with the condition of the work being completed in 20 months. The task began on the 23rd of May, 1875 and the building was ready for occupying in July, 1877, six months longer than the stipulated time, extras taking the price to £25,000. The Building Commissioners of the Province undertook to provide good bluestone, free from holes and fine honeycomb and fine, axe-dressed for the base of the building and the ashlar or hewn slabs to face the rubble wall construction. These dressed stones and the bluestone rubble were prepared in the Mt. Eden gaol. Four prisoners were seconded to load the contractor's drays for the uphill one mile trek to the site. Perhaps with the cracks in the walls and floor of the old hospital in mind, it was stipulated that the flooring of heart kauri had to be stacked 12 months for thorough drying before being laid.



By the 22nd of November, 1876, when the building was well advanced, John Taylor, the contractor, invited a number of interested people to inspect progress and partake of a champagne luncheon. Among the group that Messrs Taylor, Herepath and Derrom (the clerk of works) showed around were the four Public Buildings Commissioners. Each had personally guaranteed £5,000 at a time when the precise means of paying for the building had been uncertain. The top floor was nearly complete and the first floor partially completed, but there were no ceilings, floors or wall plastering in the ground floor. After a sumptuous meal, there were eulogistic speeches, praising the site, the view, the building and the men concerned in the design and the construction. The Chairman of the meeting, Mr. G.M. O'Rorke, thought the hospital simply a palace, and it was fit for the residence of a king. The contractor was delighted with the praise of the group and directed the credit for the luncheon arrangements and the building design to Mr. Herepath. In a modest and succinct speech, the architect spoke of the help he had had from the plans of Bedlam Hospital and how he had had to redraw the plans after a fire in the Post



Fig. 11. The Auckland Hospital, taken from the backyard of one of the houses on Symonds Street. Looking across Grafton Gully, past the store which still stands in Grafton Road, the long low building nearest the road is the lower refuge, from which a fence runs out to the left. This is the boundary of the hospital reserve at that time. The first hospital, with its various outhouses, is situated to the right of the main block. Park Road, with its white painted, wooden fence, is running along just in front of the high trees on the skyline. The split paling fence in the foreground, vegetable gardens and the back yards of the small cottages add charm and interest to the scene. In contrast the hospital has a forbidding air.

drugs without the authority of the medical officers. These drugs and some of the instruments were being used outside the hospital. People were appropriating other hospital property, as well as the property of the patients as they were admitted. The wards were ill-kempt and the cleanliness of the bedding and the patients themselves was unsatisfactory. It was apparent that the organization and disciplined running of the hospital was beyond the powers of the staff and of Dr. Philson, worn out by 18 years of toil and repeated episodes of blood poisoning following cuts sustained during surgery on septic cases. Another cause for concern was Dr. Philson's understandable reluctance to undertake surgery at that time.

One must remember chloroform anaesthesia was hazardous and in 1877 Joseph Lister had just moved to London, where he was to make more widely known his new antiseptic techniques for surgery. Despite some clear statements of the commission and a list of recommendations, it seems that only one was fully implemented, with the appointment of Mr. C. Cooper as the resident dispenser in June, 1877. Although there was much discussion as to whether Dr. Philson should continue as the provincial surgeon, it appears that the esteem with which the community held him prevailed. It would have been most unjust to suggest his retirement just at that time, when all he had fought for over the years was about to be realised.

Conditions at the hospital in 1883 (Fig. 11).

In this year the government appointed the first inspector of hospitals, in the person of Dr. G.W. Grabham. His report set out in graphic terms the fate of that beautiful new building in its first six years of service. One approached the hospital through a wilderness, absolutely devoid of shrubs, lawns and flowers. In the wards vermin abounded, the mattresses were filthy, none of the rooms had been cleaned, bathrooms were littered with rags and rubbish and window-sills packed with medicines and dressings, for which no proper place was provided. The beds of crippled patients had not been made for days. This description applies to the male wards, housing approximately 88 patients, and tended by one male nurse with convalescent patients doing the bulk of the tasks. The operating theatre had not been used and there was no evidence of surgical instruments, case books or medical records. There were two exceptions. One was in the male fever ward, where eight typhoid cases were being nursed by one old patient, who had his small ward immaculate. The matron and her two nurses looked after eighteen women, and they had their ward and charges in a clean condition, but they were tending ordinary patients as well as contagious patients.

What were the reasons for this sorry state of affairs? In retrospect, the reasons were very simple. The Committee of Management of the Hospital had not provided sufficient staff. At that time, two medical officers, three nurses and one steward were looking after 98 patients. The nurses had had only a meagre training and at that stage there were virtually no nursing traditions. With the exception of one night nurse in the fever wards, they all lived out, so supervision and care of the patients was limited to daylight hours. In fairness to the Committee staffing schedules for hospitals, as distinct from poor houses, had not been well worked out, even in parts of England. In the colony, which had attracted vigorous young people, there was probably a lack of sympathy for the waifs of society, who made up the majority of the hospital's patients. Their natural standards of cleanliness and tidiness were not high, even in perfect

Office building had destroyed the original designs.

Work proceeded steadily over the next eight months and the building was occupied in July, 1877. It is puzzling that no official function marked the opening of this building, despite broad hints from the community.

Public concern with the administration of the new hospital.

With a spanking new hospital nearly completed, the Provincial Government was anxious that the conditions in the old hospital did not carry over into the new building. It wanted the running and its administration to be in keeping with the noble lines, the up-to-date amenities and the spacious layout of the new edifice. A five-man commission was appointed to look into the running of the old hospital and to make recommendations for the new. The committee submitted its report just prior to the opening of the new hospital. Their findings were disquieting.

Apart from the problems inherent in the old building, it was obvious that many lax practices had crept in. A variety of people had gained access to the hospital

health, let alone during illness. Within the male wards, each was a small, almost self-sufficient community, with the more acutely ill patients getting a daily medical consultation and direction as to treatment from the kindly Dr. Philson. Austere meals were provided, but for the rest they had to fend for themselves, convalescent and longstay patients, according to their conscience and capabilities, caring for their sicker fellows in a palace formerly fit for a king. Judged by the best hospitals in England, which Dr. Grabham knew personally, conditions at the Auckland Hospital were both appalling and disgusting. It was, he said the worst hospital in the colony. Yet viewed from a humanitarian angle, the pitifully few staff and the convalescent patients were caring for sick people to the limit of their energies, standards and resources. The Committee and the community had built the hospital, but had not provided a sufficient sum for its staffing and running.

England and on the Continent. Her training incorporated the traditions of Florence Nightingale, who had been working diligently over the previous years to upgrade the nursing profession in England. Miss Crisp was appointed to the hospital in June, 1883. Backed up by Dr. Mackellar, she persuaded the Committee to increase the number of nurses, and by the end of the year had one male and 13 female nurses to replace the old staff. The principle of female nurses working in the wards for men was established. She urged the setting up of a training scheme to attract intelligent and educated young women as probationers, to provide a supply of skilled, reliable nurses. This scheme had to wait until 1889, until the Board had built a cottage to accommodate the nurses. During the intervening six years, the small accident ward on the top floor of the main building was converted to a nurses' dormitory, while the board room on the first floor served as their dining room.

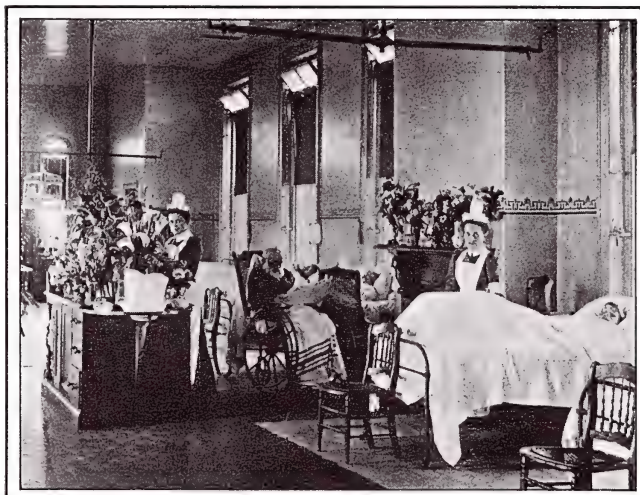


Fig. 13. The accident ward on the second floor in 1900. A sister is standing at the centre-press, tending her flowers. One set of gas lamps holds two caged birds. The adjustable louvres at the top of the casement windows allow for circulation of air. The dilapidated camp stools of 1883 have been replaced by chairs. An old patient is enjoying the warmth of the fire, the only means of heating the ward at that time. The general atmosphere of this ward appears more homely than our present wards, dominated by vinyl and stainless steel.

Fig. 12. Annie Alice Crisp, matron from 1883 to 1889. This young woman had a strong impact on the hospital when she was first appointed. Imbued with all the ideals and aspirations that Florence Nightingale had given the profession, with a clear insight into the problems and priorities of the situation, and endowed with a fierce energy, she was to transform the hospital in a few short months. She subsequently married Dr. John Bond.

1883 — a year of change.

A serious illness towards the end of 1882 compelled Dr. Philson's retirement in January, 1883. His friend and champion, Dr. Goldsbro' who had helped him a great deal in the last few years, took charge of the institution for two months, until Dr. E.D. Mackellar was appointed senior medical officer in March, a month when the new Committee of Management of the Hospital met for the first time. Later in the year the committee appointed the first honorary staff, comprising Drs. Philson and Goldsbro', consulting surgeons, Dr. Haines and Stockwell, visiting physicians, and Drs. Richardson and Cooper, visiting surgeons. These appointments provided the hospital with a young, enthusiastic senior medical officer and quadrupled the number of medical staff. Within a few days of Dr. Mackellar starting work, the old matron, Mrs. Bryce, resigned in protest, and Mrs. W.H. Kissling, a qualified nurse, volunteered to take charge of the nursing department until a matron could be appointed.

By a stroke of good fortune, a Miss Annie Alice Crisp had just arrived in the colony as a nurse accompanying a group of immigrant young women (Fig. 12). She had been trained at Netley Hospital, a large military institution near Southampton and had ten years' graduate experience in civil and military hospitals in

The Auckland Hospital had the benefit of Nurse Crisp for the next 13 years. She, and a growing cadre of nurses trained first informally and later under prescribed training schemes, was to provide a steady standard of excellent care, despite shortage of money, the onslaughts of epidemics and a continuously changing medical staff in conflict among themselves and with the Committee and later the Auckland Hospital and Charitable Aid Board.

The year 1883 was certainly a milestone in our history. In three short months numerous key appointments had been made and Dr. Mackellar and Nurse Crisp turned the place upside down. While Dr. Mackellar resigned in August, 1883 to take up private practice, in those six months his clear insight into the problems besetting the hospital, and his forthright manner with the new Committee of Management of the Hospital achieved much. Dr. Bond took over from Dr. Mackellar. By December of 1883, when Dr. Grabham paid a second visit to the hospital, all the wards had been refurnished and linen presses, bed tables, shelves and receptacles had been fitted (Fig. 13). The old camp stools had been burnt and replaced by comfortable chairs. Utmost cleanliness prevailed throughout the wards. The institution had become a real hospital, caring for sick patients, rather than a poor house and an infirmary for old men.

Problems in medical staffing and relationships with the Board 1885-1913.

During this 30 year period a variety of schemes for staffing the hospital were tried out, before a reasonable working relationship was forged between the resident medical officers, including the medical superintendent, the honorary staff and the Auckland Hospital and Charitable Aid Board. The Board was made up of concerned lay members of the public, some of whom were successful business men. Although the resident medical officers were technically the employees of the Board, they in no way resembled the docile employees in a business enterprise at that time. The honorary medical staff, by seniority, were even more independently minded. They were not employees of the Board, in that they were not paid an honorarium. They were held to the hospital by a loyalty and by the status of their position. They also had a genuine desire to look after patients in an honorary

adequate residence in the hospital grounds and provide a reasonable salary to attract a capable senior medical superintendent. One can see now how futile it was to expect relatively junior and untried medical graduates to take charge of a provincial hospital. In England and Scotland, whence most of the medical men came, house surgeons and house physicians joined hospitals for one to three years' experience without pay, prior to setting up in private practice. Many of the graduates arriving in Auckland had been through these years and the best of them were anxious to establish themselves in private practice, rather than go back to the hospital life in a junior capacity.

The period of dispute and rancour came to the end with the appointment of Dr. Charles Maguire, in 1911, a man of considerable talents, the foremost being that of a diplomatic negotiator. In his subsequent 21 years of service as medical superintendent, he established good



Fig. 14. The staff of Auckland Hospital in the 1880s. The tall bearded man with the tapestry hat and his companion with the domed forehead are probably resident medical officers of equal status. The stiff central figure with the top hat may be the secretary of the hospital. One senses a certain tension between this man and the rest of the staff, and one wonders if the matron is deliberately turning her back on him, or merely taking up a becoming pose. This tension between the lay administrative staff and the medical and nursing personnel was at its height at this period. The two men in aprons could be male nurses or cooks. Among the other men would be the dispenser or pharmacist. With all the women, their faces, carefully groomed appearance and spotless aprons give an impression of pride and dedication in their profession.

capacity, as well as having the hospital facilities to admit some patients from their own private practices. As a profession, doctors have always been very individualistic, and this may arise in part from the one to one relationship with their patients, from the self-esteem arising from the trust and respect accorded to them, and from their day to day concern with the vital matters of health, life and death. They did not take kindly to a Board, made up of people without medical or nursing training, directing them in medical matters and the running of the hospital. The Board for its part had a public responsibility and its yardstick of success was service to the public on as economical scale as possible, and its models were business firms and local body enterprises. In their years of service between being appointed, members had little time to learn about the running of the hospital, and the handling of that odd breed of man, the medical doctor. There was an element of parsimony in their planning, necessitated by their inadequate funds to meet the rising costs of a growing institution and trying to keep pace with a rapidly expanding population and advances in medical knowledge.

In looking back on this period, one wonders if many of the difficulties in getting a medical staff would have been eliminated if the Board had decided to build an

relationships between himself, the full-time medical staff, and the honoraries and reconciled the differing viewpoints between the honoraries and the Board.

Dr. Bond charges the honoraries with neglect of their patients.

The period had begun with Dr. Mackellar's six months' tenure as the senior medical officer. He was assisted by six honorary medical staff. His successor was Dr. Bond, whose conditions of appointment were such that he worked under the direction of the honoraries. He proved to be extremely conscientious. With a single loyalty to the hospital and increasing experience, it was inevitable that he should come into conflict with the honoraries over the care of their cases. In 1886 he made a written complaint to the Board about the irregularity and paucity of the honoraries' visits to the hospital, alleging that their hospital practices seemed to take second place to their private work. In reply, the honoraries felt that Dr. Bond did too much for the patients, encroaching on their functions as visiting staff. Dr. Bond's claims were difficult to prove, as no records were kept of the days and hours of attendance of the honoraries. Over the next two years the situation smouldered. The Board did consider appointing a senior doctor, but were deterred by the cost of



Fig. 15. A view of the old Cemetery Bridge across Grafton Gully from the graveyard below Symonds Street. The time is 1889. Beyond Grafton Road is the newly constructed Nurses' Home, the first hospital and the old main building in that order. One can appreciate the criticism of the hospital being too far out of town. It must have been a long trek up Queen Street, along Karangahape Road and often it took ages to cross Cemetery Bridge, because of the wait for traffic coming from the other side. The Stanley Street and Grafton Road route may have been marginally shorter, but it was just as steep.

providing his accommodation. Eventually Dr. Bond resigned. His period at the hospital had had its compensations. He married Nurse Crisp.

In 1887 the Board appointed two junior doctors in Dr. Bond's place, Thomas Bell and P.A. Lindsay. Three letters of Mr. H.N. Garland, the secretary of the Board from 1883 to 1918 are extant, appointing Dr. Lindsay as house physician in charge in May, 1887, and re-appointing him December, 1887, for the next year. The first letter refers to Dr. Franklin's dismissal, and this doctor served the Board from the time of Dr. Bond's resignation. Dr. Lindsay later became a general practitioner in the Herne Bay area, specialising in obstetrics, as did his son, who was also a paediatric

surgeon attached to the Auckland Hospital for many years. Drs. Lindsay (senior) and Bell continued as resident staff until 1890. (Fig. 14).

The Board dismisses the entire honorary staff.

The uneasy relationship between the honorary medical staff and the Board came to a crisis in 1889, when the honorary staff refused to enter their names in an attendance book in the hospital. This gave the Board a reason for dispensing with their services. It placed the whole management of the hospital under a resident medical superintendent, Dr. Floyd Collins, with Dr. Bell staying on as his assistant. In this move, the Board virtually excluded the medical profession in Auckland from the Hospital, replacing the combined experience of six senior men with the full-time efforts of two doctors, the senior one of whom was of unproven worth.

The year was not out before a probationer nurse, Miss Arnaboldi, complained to the Board about the new superintendent's alleged negligence regarding two patients, a matter the Board chose not to investigate. However, some weeks later the governor, Lord Onslow, ordered a hospital commission to be set up. Although Dr. Collins was exonerated, it prompted the comment from the inspector of hospitals that some representatives of the medical staff should be on the governing bodies of large hospitals. As a result of the adverse publicity about this incident, the Board conceded to return to the old system of an honorary medical staff. In 1891 they published a book of rules and regulations for the Auckland Hospital to guide the medical staff.

A period of calm with substantial progress 1895-1900.

The resignation of Dr. Collins came in 1895, after some years when the hospital was beset by innumerable petty grievances within the institution and with the Board. A new start was made with the appointment of Dr. Pearce Baldwin and Mrs. Wooton as matron, and the next five years was a period of smoother running and expansion. The kitchen in the ground floor of the main building, permeated by odours of the mortuary, was replaced by a separate building on the south facade, and the building of the Costley Block took place. It was a pity that Dr. Baldwin's resignation was prompted by the Board

Fig. 16. An operation takes place in the Costley theatre about 1910, when the hospital was electrified. The patient is having chloroform anaesthesia, using a dripping bottle and gauze mask. Rubber gloves were not in universal use at that time. Face masks had probably been removed for the purpose of photography. Note the chipped enamel bowls.

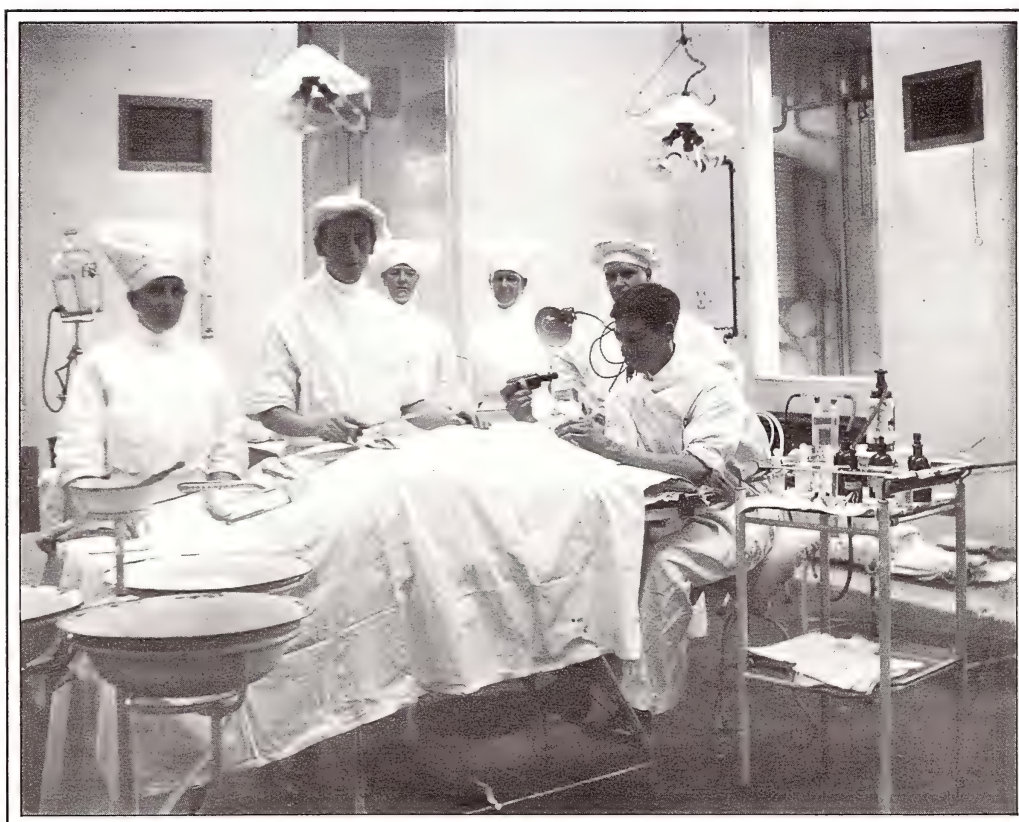




Fig. 17. Auckland Hospital in 1908 from the gate into the Domain. The post and rail fence was the boundary of the hospital land at that time. The subsequent erection of the present Ward 12, the Infectious Diseases Block and the Princess Mary Hospital all involved annexing land from the Domain.

Just inside the gate is the Emergency Ward, starting life out in the Domain as a smallpox hospital (£150 in 1887), and removed to this present site in 1905. Much later it was to become the headquarters of the District Nursing Service, later the Radio-Isotope Unit and Thyroid Clinic, when it was extended. It is now the present home of the Dental Department. The road now runs to the left of this Emergency Ward.

On the right is the Observation Ward (£1500 in 1907). It later became Ward 20 and is now the present Medical Centre. Further to the right are the Infectious Diseases wards, comprising Wards 18 and 19 and a cottage for nurses who were working in the wards at the time. Ward 18 now houses the Renal Dialysis Unit and Ward 19 forms part of the Nursing School.

Further up the hospital site is the two storeyed, nine roomed house (£1309 in 1904), built for the medical superintendent. It accommodated resident medical staff until 1914, when Dr. Charles McGuire took it over. Alongside the Costley wards is the first Nurses' Home (£500 in 1889) and its extra wing (£875 in 1900).

cancelling well-earned leave after a period of intense activity, preparing for a plague epidemic which did not eventuate. His mis-diagnosis of a 14 year old boy as suffering from plague had probably unjustly marred his reputation with those members of the Board with commercial interests.

The Board fails to appoint a new superintendent.

Despite the lessons of previous boards and the developing traditions of hospitals around the world, the Board chose to revert to putting the hospital in the charge of two junior resident doctors, Dr. Tracy Inglis and Dr. Adams. The Board appointed Dr. Bedford to the post of senior medical adviser, which involved chairing the honorary medical staff meetings and reporting to the Board. One wonders what role the secretary, Mr. H.N. Garland, played in Board affairs. Mr. Garland held that post from 1883 to 1918, providing continuity through successive changing membership of the Board, but there was no evidence of whether he actively tried to steer the Board one way or another. If strong and wise, he could have prevailed against this move away from the medical superintendent, or he may have actively encouraged it, if he was of an autocratic nature. The new arrangement certainly put the hospital more firmly under the Board and saved £500 for its annual budget.

The two junior doctors found the new arrangement unsatisfactory and there was concern in the community about the hospital being in the charge of two junior, relatively inexperienced men. Satisfied with Dr. Inglis's work and capabilities, he was put in charge of the hospital for a short period with Dr. Adams and one other doctor occupying the junior posts. Eventually, the Board capitulated to mounting community pressures and appointed Dr. Clive Collins as medical superintendent. Under new rules he was entitled to attend all meetings of the honorary medical staff and act as an intermediary between the honorary staff and the Board. The decision to reappoint a medical superintendent was wise, although the choice of the man for this position proved to be most unfortunate. Two years of intense friction ensued, with the dominance of the medical superintendent and the resignation of most of the visiting staff as consequences.

Some idea of the difficulties of this time can be gauged from the circumstances of the dismissal of Dr. James "Tom" Hardie Neil (senior) from the honorary staff. He was giving the anaesthetic to a patient with a perforated peptic ulcer, misdiagnosed as appendicitis. Dr.

Collins removed the appendix. The patient died some days later and Dr. Collins ascribed the death to the anaesthetic, blaming Dr. Neil. The patient had died of peritonitis, as a result of the misdiagnosis and failure to oversee the ulcer. In response to Dr. Collins' complaint to the Board, Dr. Neil was dismissed. Incensed by this injustice, Dr. Neil refused to resign, maintaining that no proper reason had been submitted by the authorities. This high-handed action by Dr. Collins and the Board was the culmination of a prolonged campaign to denigrate the honorary staff, by calling on them for useless consultations and minor operations. On the plea of urgency, the medical superintendent had claimed and performed an unfair proportion of the major operations. Dr. Neil's persistent efforts secured a Royal Commission to investigate the hospital management.

Their findings raised doubts as to the running of the hospital and Dr. Collins' own standards of practice. The Commission resorted to the exhuming of the body of one patient, the examination of which proved false some of Dr. Collins' previous statements. The findings compelled the resignation of the superintendent.

In 1905 Dr. Walsh was promoted from the resident staff to take Dr. Collins' place. Dr. Robertson was chairman of the honorary staff medical committee at the time, and determined efforts were made to restore the prestige of the hospital. The honorary staff was augmented by the appointments of a bacteriologist, pathologist and dental surgeon. For a few years both honorary and resident medical staff worked in harmony. Intensive structural work to the hospital was carried out during this period, with the addition of further wings to the Costley Building, the installation of a lift in the main building and a complete refurbishing of the two wards on the ground floor of the main block.

In 1911, the Board was disturbed by conditions in the hospital, and felt once more that the honoraries were not working together in the best interests of the institution, under the chairman of the medical committee and a relatively young senior medical officer. Rather than make a permanent appointment of a medical superintendent too hurriedly, as they had done in the recent past, they appointed Dr. Charles Maguire as the senior resident medical officer. As a graduate of Aberdeen, he had had some first class experience as the principal medical officer of Tonga. He took up residence in the home of the former house-steward. In two years he had proved himself fully capable of managing the

institution and dealing with the staff and the Board, so that in 1913 he was officially appointed as the medical superintendent. In that year and the following, new rules were discussed and formulated. According to these the superintendent undertook all the administrative work, but was relieved of any medical work of a routine nature, except for emergency cases, if no member of the honorary staff was available.

Dr. Maguire moved into a house built in 1904 for the medical superintendent. At long last the Auckland Hospital had at its head an able man, living in dignity within the grounds, backed up by a loyal resident medical staff and a group of honoraries who were respected for their service and their skills. Under Dr. Maguire's wise and diplomatic leadership, the conditions for the staff and the patients, the quality of work and the prestige of the hospital all improved. Throughout the previous thirty year period of turmoil involving the medical staff, the work and the evolving standards of excellence of the nurses was a considerable influence in maintaining reasonable care of the patients. Their profession was attracting probationers of good educational background, imbued with a strong sense of service. The hard work of nursing people, particularly through epidemics and the formal education available to these probationers made first-class nurses of those who completed the course.

By the end of World War I the Auckland Hospital was in good shape and morale was high. This was just as well, for with the arrival of R.M.S. *Niagara* from Vancouver on the 12th of October, 1918, bringing to New Zealand the influenza epidemic, the hospital was faced with the most severe civilian crisis in its entire history.



Fig. 18. The first hospital ambulances with their drivers, parked outside their garage close to Park Road. The first one cost £695-13s-3d, and was put into use in March, 1915. During the previous year, the citizens of Auckland had raised almost £867, to which was added a government subsidy of nearly £1014, and this sum secured two Napier ambulances, one Ford car costing £267-10s and another car costing £180. From this start, the large fleet of St. John's ambulances, with their corps of carefully trained drivers, has developed.

SOME IMPRESSIONS OF A RESIDENT DOCTOR IN 1928

Edward Roche

As not only beauty, but all impressions are "in the eye of the beholder", it may be pertinent to sketch very briefly the background of the person through whose eyes readers are asked to look at the Auckland Hospital in 1928.

Firstly, although I am a third generation New Zealander, it was decided that I should study medicine at Guy's Hospital, London, where one of my grandparents, Arthur Guyon Purchas, had qualified. World War I broke out on the 4th of August, 1914, when I was on the high seas. In London everyone was certain that the war would be over in three weeks. Therefore, I began my studies as planned, but after a year, the war having taken a more serious turn, I joined the British Army and later went to France with a battery of six inch howitzers. Towards the end of the war, while second-in-command of the battery, I was severely wounded and spent nearly two years in various British hospitals. The fact that it took nearly two and a half years to heal the infection of my foot illustrates one of the problems of pre-Penicillin medicine. With antibiotics I could have been out of hospital in a few weeks with only slight permanent disability. After a further year in New Zealand, my wounds finally healed. In 1921 I went back to Guy's Hospital, though still far from fit, to pick up with great difficulty the threads of study I had dropped in 1915. After qualifying, I served for nearly two years as a resident at Guy's, before returning to New Zealand.

Thus it came about that in May, 1928, I went to the Auckland Hospital to see the medical superintendent about a job. On my way to his office I was intercepted by his assistant, Dr. H.L. 'Nat' Gould. In my long sojourn in England I may have acquired something of an English accent, but whatever it was, Dr. Gould was immediately suspicious of me. When I mentioned I had qualified in London, he said at once, "No vacancy". It was my first and only experience of the hostility of some Kiwis to the Pommies, who after all, have made New Zealand what it is. I weighed him up very quickly and went past him to his superior, Dr. Charles E. Maguire, who, by contrast, was affable and friendly (Fig. 19). After a brief chat he said he would be pleased to have me on the resident medical staff at a salary of £200 a year. As residents at Guy's Hospital received no salary at all, this seemed most generous.

Charles Maguire, a graduate of Aberdeen, was an extremely pleasant, tactful person, who was easy to get on with. To illustrate these qualities, I well remember one woman who, as she was being anaesthetized, overheard a resident doctor make a remark about her lovely hair. She took exception to this and complained to the medical superintendent. Charles Maguire, when confronted with this irate woman, looked intently at her hair and said in a gentle voice, "I can really understand that remark. It certainly is beautiful hair!" The patient immediately changed her attitude, smiled and left with complete satisfaction. In the frequent wrangles between the honorary staff and the Board members, Charles Maguire was a skilful and astute diplomat. The honorary staff of course received no pay, which gave them great power and also perplexed the Board members, who seldom understood the predominantly altruistic motives which inspired so much of their work.

During his later years Dr. Maguire's eyesight began to fail. It was his practice to visit some of the wards each day, saying "Good Morning" to every patient with a smile. These visits to the wards were encouraging, both to the staff and to the patients. However, sometimes he would say "Good Morning" to an empty bed, and no-one laughed because he was held in such respect.

I was assigned first to Ward 2, on the ground floor of the old main building. It was a medical ward for less acute cases. On my first morning I took over from Dr. Barbara Henry, and as we proceeded around the ward, I found my interest straying from the patients to the doctor. Thus began a romance which still blossoms after nearly 50 years.

Dr. W.N. 'Tiny' Abbott and Dr. W.E. Williams, both graduates of Melbourne and both general practitioners, were the honorary physicians. Dr. Abbott was a big, well-built man, who had rowed and played football as a student. He served in World War I and graduated in 1920. He then settled in Auckland and set up practice in Epsom. At one stage he was interested in the scale-buoy, a device which when placed in the radiator of a car was said to prevent the formation of scale. He thought water which had been acted upon by this device might have medicinal properties, and he used it widely in his private practice. This theory, however, was not accepted by his colleagues and scale-buoy water was not used in the hospital during my time. Dr. Abbott's son, David, became a colleague of mine, as a physician in the Chest Department at Green Lane Hospital, and he later specialised in radiology.

Dr. Williams, a much older man, graduated in 1897. He thought deeply and was a sound physician and skilled obstetrician, in spite of having had no postgraduate training.

My next assignments were to Mr. A. Eisdell Moore, a kind and skilled general surgeon, from whom I learnt much clinical wisdom. Later he was an external examiner at the Otago Medical School, chairman of the Council on Appointments and president of the New Zealand branch of the British Medical Association. Dr. Frank Macky was the other honorary. He was a pioneer of urology in Auckland. I assisted him at many cystoscopic examinations and retrograde pyelograms, but I found him perhaps a little cagey about imparting any of his special skills. When chairman of the medical staff he initiated the establishment of the Board's Council on Appointments and served as a chairman of this body.

The surgeon was the widest reputation at home and abroad was Sir Carrick Robertson, a Guy's man. Though not an infallible diagnostician, he thought deeply about the surgical method and technique. He had a system of signals, whereby his assistants knew a few seconds in advance what instrument to have ready. With both hands working at top speed and his mind ten moves ahead, he performed swiftly and deftly. In the days when prolonged anaesthesia was fraught with danger, speed could be a factor for safety.

My last three months as a resident were with Dr. T.W.J. Johnson. After twelve years of general practice in Napier, he had spent two years in London attending clinics. Then, with his M.R.C.P. (London) he came to



Fig. 19. Miss Ada Taylor, matron from 1918 to 1928, flanked by Charles Maguire on her left, the medical superintendent and William Wallace, the chairman of the Board on her right. Under Charles Maguire's able leadership, morale within the hospital grew and its reputation in the community was enhanced.



Fig. 20. The southern aspect of the old main building about 1930-1937. All patients had to walk or be carried up these steps for entrance to the wards until 1910, when a single slow-motion lift was installed. The towers, situated half way along the two wings, were erected in 1908, to provide modern plumbing facilities to service the bathrooms, washing facilities and lavatories. Obsolete, leaky drains in the corner towers had compelled this replacement.

The spacious quadrangle was known as the "desert", in the centre of which is pictured the Phoenix palm in its youth. It was to grow to a large size, despite a fire in its fronds, set off by sparks from the nearby chimney. On the right of the desert is the kitchen block with its store and dispensary, completed in 1896 at the cost of 1020. Wards 8 and 9, originally built as infectious units, are situated to the left of the desert. On the western end of the old main building is a Norfolk Pine, which was to grow above the roof line of the three storey building. It was the regular practice to decorate this tree at Christmas, and the old hospital staff grieved when it had to be cut down to make way for the new block. Parking was not a problem in those days.

Auckland about 1925, where he was the first consultant in general medicine, refusing to visit any patient in his home unless requested to do so by the general practitioner. He would, however, see all and sundry by appointment at his rooms. He was a most able physician and I learnt a great deal from him. He had all the latest techniques in the use of insulin for the treatment of diabetes. In fact it was said that he came out on a tide of insulin. This gave him a flying start in consulting practice. He was for many years the unquestioned leader in all fields of medicine, except paediatrics, where Sammy Ludbrook reigned supreme. Dr. Johnson had a very astute mind and was very quick in diagnosis. In his private practice he seldom spent more than 15 minutes with any patient, but in spite of this speed he rarely made a mistake. He read widely and quickly, assimilated everything and had it at his fingertips. He was a most stimulating teacher.

There were two other colourful senior staff members at the time. Alexander McGregor Grant (Granty) qualified in Melbourne in 1910. Once as acting medical superintendent he kept a racehorse in the grounds of the Auckland Hospital, trained it in the Domain and rode it himself at Ellerslie. After World War I, he was an astute, capable and popular general surgeon, who was noted for his very small, (seldom more than one inch) incisions, through which he removed countless acute appendices. He later became president of the Auckland Racing Club. James Hardie Neil was an ear, nose and throat specialist, and the subject of more good stories than any other doctor. Though close-fisted with money, he was unstinting with his time and talents when any patient was really ill. He founded the Auckland Clinical Society in 1921, developed the art of bronchoscopy and did valuable research on the anatomy of the lungs, discovering a new bronchus.

There were no registrars, but John Mark was recognised as the senior resident, with some supervisory

control over us. He was discreet and as modest as he was competent and we listened carefully when he ventured to make any comment. After postgraduate experience in London, he returned with his F.R.C.S. (England) and built up a large surgical practice in Tauranga. Pat Murdock also went to London, where he settled. He has recently retired as consulting surgeon to the Royal Postgraduate Medical School at Hammersmith. Chisholm McDowell went to the Brompton Chest and National Heart Hospitals in London, and on returning with his M.R.C.P. (London) began consulting practice in Auckland. He then took over the cases of pulmonary tuberculosis at the Costley Home (now Green Lane). There he introduced the scientific treatment of tuberculosis and built up a very fine department for the treatment of chest diseases. Russell Chisholm, with an M.D. from Melbourne, and postgraduate experience in London, returned with his M.R.C.P. and was appointed clinical tutor at Dunedin. He then practised in Palmerston North. During World War II he was Director of Medical Services to the New Zealand Air Force. After the War he was physician at Auckland Hospital for sixteen years and is still in private consulting practice, with special interests in aviation and insurance medicine. E.P. Spencer and A.L. de Berri 'Alf' Noakes became brothers-in-law and practised in Remuera and Onehunga respectively. Alf Noakes also had several years' war experience.

John H. North returned from London with his F.R.C.S. and after two years a clinical tutor in Dunedin he moved to Palmerston North. For twenty years he was surgeon and medical superintendent. He then took up the post of superintendent-in-chief of the Wellington Hospital Board. Other residents at the time were Jessie Alexander, who practised with her husband (Burnett) in Hunterville for five years. When he retired through ill health, she moved to Wellington, where she practised as an anaesthetist, and has now retired to Palmerston North. In 1966 she had the honour to be elected without

examination as F.F.A.R.A.C.S. Kathleen Abbott settled in the north of England. Jenny Wood (now Fougere) practised in Kaikohe and then retired to Kawakawa. L. Rexford (Rex) Hetherington graduated in Edinburgh and came straight to Auckland, where he was a resident for 18 months. He then practised in Waihi for 43 years, and has now retired to Taupo. My own wife, Barbara Henry, gave anaesthetics at the hospital throughout World War II, but has not otherwise engaged in practice (Fig. 21).

Tracing the subsequent careers of my fellow residents has shown me how widely they have diverged in their practices, skills, achievement and place of work. We all had in common an intense, formative experience in Auckland Hospital, where our theoretical knowledge was shaped by the practical experience with patients and interactions with the clinicians. In this way the hospital was an educational institute, although by present day standards it was not a centre of postgraduate medicine. Its role in undergraduate teaching went back only one year to 1927, when it accepted for the first time a group of Otago sixth year medical students. Formal postgraduate activity had its beginnings during the war years, while undergraduate teaching continued from 1927, being strengthened in 1938 by the formation of a branch faculty of the Otago Medical School and ultimately flowering with the formation of our own School of Medicine in 1968.

The main difference in my training at Guy's and the training at Otago was that, after anatomy and physiology, we had very few lectures at Guy's. We spent as much time as possible in the wards, with 95% of our clinical teaching taking place at the bedside and in the autopsy room. In Otago they spent a good deal of time in the lecture room and so had much more theoretical knowledge, but less practical knowledge than I had. The point about bedside teaching is that what you learn at the bedside tends to come back more readily when you are at the bedside. When I returned to Auckland I found the Otago graduates could rattle off half a dozen causes of polycythaemia, whereas I could think with difficulty of only one or two — the common ones. It was interesting to me that after I had been at the hospital for a number of months, some of the residents would occasionally ask me to see some of their more difficult cases. From bedside impressions I was sometimes able to point to the diagnosis. In cardiological cases I sometimes had the temerity to tell them in advance what Dr. Johnson would say about the patient's heart murmurs and what Dr. Sammy Ludbrook's diagnosis would be. These predictions were strikingly borne out when the senior consultants recorded their opinions. Perhaps that was the embryological start to my career as a cardiologist. The only thing that impressed me unfavourably about the Auckland Hospital was the incredible degree of unnecessary noise in the wards, and this still worries me. Sick people, especially the elderly sick, long for quietness and noise robs them of their strength.

One of the advantages of working in a hospital like Guy's, was that we did see some rare cases, and we were encouraged to make our own investigations on them. I

remember one patient coming into Ward 2 in the old main block of Auckland Hospital. It reminded me very much of a case of actinomycosis that I had seen at Guy's Hospital. I took the trouble to take a swab from a discharging sinus and put it under my microscope. Clearly visible were the small, yellow, sulphur granules, diagnostic of that condition. For the hospital records I sent a swab to the laboratory and wrote on the form '? actinomycosis'. The senior technician at the time in the laboratory was a Mr. Armitage. He was a very able technician indeed, but he also liked to assert his authority and took every opportunity to jump on to the back of any new doctor who exceeded his duties in any way. The other technicians told me afterwards that when he saw my diagnosis he just about hit the roof. He reached for the telephone and gave me a severe 'dressing down' for thinking of such a rare disease. He argued quite rightly that the more common diseases should have been uppermost in my mind. But, in reply I pointed out that I had examined the discharging pus under my microscope, and it was actinomycosis, because of the characteristic yellow granules. I had merely referred it to him for official confirmation. His staff told me that on hearing this he



Fig. 21. The resident staff of the Auckland Hospital in 1928. The back row comprised Stuart B. Mackay, John North, J.D. "Pat" Murdock, Chisholm McDowell and A.L. de Berri Noakes. Standing at the left of the front row is Barbara Henry (now Roche), Kathleen Abbott, E.P. Spencer, John Mark and Jessie Alexander (now Burnett). Some of these residents were the first Otago students to come to Auckland for their sixth year training in 1927.

collapsed like a pricked balloon. He confirmed the diagnosis as requested.

Residents at that time had no regular days or weekends off. However, we enjoyed a good deal of freedom to go out, provided we had arranged for someone to be on duty. Barbara Henry is believed to have been the first resident at Auckland Hospital to acquire a car — a

new two seater Essex. I came next with nearly new two seater. Pat Murdock followed with his 'Beatle' — the smallest Ausin ever built. After announcing our engagement, Barbara Henry and I were lured into this car one Sunday morning and pushed by our colleagues into the old Costley Building, along the corridor and into the theatre, around the operating table and out again. We were subsequently invited to be guests of honour at a champagne dinner given by our fellow residents at one of Auckland's leading hotels. There were eight in the party and they gave us a sumptuous dinner, with no expense spared. However, when it came to footing the bill, it was found that I was the only one who had brought any money, and I had to 'lend' what was necessary to our host. There was a fine spirit of friendship and conviviality at that dinner and we still look back on it with pleasure. But, by a strange quirk of memory, our charming host completely forgot to reimburse me. As regards cars, Rex Hetherington and Peter Griffiths bought cars, and we felt this fleet of five called for some concerted action. So, one Sunday, while three residents stayed behind to hold the fort, the car owners arranged an all day expedition to the wilds of Maraetai. The fleet with one or two spare residents and a goodly number of nursing staff set off in high spirits. Although one of the old cars broke down and had to be abandoned on the way out, and another on the way back, no-one was stranded. It was an old time picnic of the best kind — boiling the billy, swimming and exploring — a day we shall never forget.

A charming feature of the hospital was a pair of identical twins among the nursing staff — Marini and Muriel Jackson, whom no-one could tell apart. Even as charge nurses they could exchange duties whenever they wished, and the ward sisters were none the wiser. I thought I could distinguish them, but I was wrong. At the Nurses' Graduation Ball I managed to book a dance with one but not the other and got hopelessly mixed up. Next morning, meeting one of them in the corridor, I apologised, but again it wasn't the one I thought it was. They were both as bright and capable as they were charming, and they subsequently had distinguished nursing careers. 'Rini' left with the Expeditionary Force in

March, 1940 and progressed from Sister to Assistant Matron and finally Matron of the 3rd New Zealand General Hospital. In 1943 she was awarded the Royal Red Cross gold medal. Returning to New Zealand in 1945 she was matron of Green Lane until her retirement in 1956. Muriel left Auckland Hospital in 1941 and became Charge Sister at the New Zealand Casualty Clearing Station in the Middle East. She then became matron of the Fifth New Zealand General Hospital and in 1945 followed Marini as Matron of the 3rd New Zealand General Hospital. She was awarded the Royal Red Cross medal in 1944. Returning in 1946 she was appointed supervisor of the Auckland School of Nursing and in 1966 became the first nurse in Auckland to be awarded the Florence Nightingale medal.

In April, 1929 I left Auckland Hospital to do a locum for Dr. Everard Rowley of Otahuhu. As he introduced me to his more 'important' patients, I learnt very little about medical science, but a great deal about the social, psychological and financial aspects of private practice. My term at Otahuhu was a challenging experience, which provided scope for every scrap of knowledge and every faculty I possessed. In October, 1929, Barbara Henry and I were married and soon afterwards we set off for London, where I divided my time between paediatrics, obstetrics and general medicine, and took my M.D. degree. After a year, finances dictated a return to New Zealand and a period of ten years in general practice. In 1932 I was appointed for three years honorary assistant physician in paediatrics with Drs. Bruton Sweet (babies) and Sammy Ludbrook (boys and girls). In 1935 I became senior honorary physician to adult wards 11 and 12 and I was also for a few years assistant at St. Helen's and Karitane Hospitals. Then, having acquired an oscilloscope, I introduced electrocardiography to Auckland Hospital. When the first acute block (wards 1 to 6) was opened at Green Lane Hospital in 1942, I was transferred there and looked after Ward 3 (adults) and Ward 1 (children). Throughout the war I gave the third year nurses' lectures at Auckland Hospital and later the 2nd and 3rd year lectures at Green Lane, and reported on the electrocardiograms at both hospitals for many years.



Fig. 22. Michael Gilmour presenting an illuminated address to Edward Roche. These men have toiled over many years to improve postgraduate and undergraduate medical education in Auckland. As medical tutor, consultant physician, sub-Dean of the Branch Faculty, chairman of the Division of Medicine and Pro Chancellor at the University of Auckland, Michael Gilmour has contributed at many levels. Here he is as president of the Royal Australasian College of Physicians, speaking on behalf of the College Fellows. The address records the debt the fellows owe to Edward Roche for his role in fostering medical education during his period of service on the Postgraduate Committee, as well as the establishment of cardiology as a specialty at Green Lane Hospital, and the initiation of the Medical Historical Library of the College, housed in the Philson Library.

EIGHT TO EIGHTY-EIGHT — a surgeon looks back.

A. Eisdell Moore

This is a transcript of the Dean's Lecture given to the students and faculty of the School of Medicine and the staff of the Auckland Hospital on September 14th, 1977.

When your Dean asked me to give one of these lectures I replied with a most uncompromising "No". I felt I was much too old to give a lecture. (I expect I am about to prove that I was right). Anyway what could I talk about that would interest the present day students?

Then I remembered that when I was a student between 1906 and 1911, I used to enjoy listening to my grandfather talking about his early days. He was then over ninety, so I suppose I have inherited a longevity gene from him. Anyway I was interested to hear him tell of the Great Exhibition of 1851, with its huge building of glass, erected in Hyde Park, and its subsequent reconstruction as the Crystal Palace at Sydenham, which I had passed on my way as I cycled across South London to visit him.

And so I thought it might be of some interest to talk about what things were like when I started medicine, and speak of some of the things that have made the greatest changes in my time, so that perhaps one of you in his eighties might recall hearing a retired surgeon tell of the days when the use of surgical gloves was a rarity.

When I told Mr. Cole that I would speak (and suggested *Eight To Eighty-Eight* as a title) he said that, because of the approaching centennial celebrations of the Hospital, would I please make some reference to the early days of the Auckland Hospital. That is where the *Eight* comes in, for I was that age when I had my first association with the Auckland Hospital. I must allow, however, that my contact was purely social. I came to a party at the home of the medical superintendent, and it was on this very spot. In 1898 I was a pupil at a little private school spoken of in those days as a *Dame's School*. It was in Claremont Street, just along the road from here. It wasn't a kindergarten according to modern ideas, and work was serious. I still remember the ridicule to which I was exposed by spelling yesterday *YESTODAY*, and that when asked if I did not know the meaning of the word, my quite sensible reply that it was "*When today was tomorrow*" brought further laughter.

The school roll totalled four, two boys and two girls, and one of the little girls, Doris Baldwin, was the daughter of Dr. Baldwin, then medical superintendent of Auckland Hospital.

There was no residence in the hospital grounds then, and Dr. Baldwin lived in a two-storeyed house in Park Road almost directly opposite the present entrance to the Domain, and on a site that now is part of this building's parking area. When Doris Baldwin had a birthday she gave a party for her three school mates, so, as I said, my first contact with the Auckland Hospital was purely social.

Years passed, and in 1905 I passed the medical preliminary. Edinburgh University, at that time greatly favoured by New Zealanders as a training ground in medicine, accepted the lectures given in the New Zealand colleges as requisite instruction for the sitting of the first professional examination, so for this reason I spent 1906 as a medical student in Auckland, and during this year had my first real association with Auckland Hospital. There were only four of us doing first year medicine and we were included with B.Sc. students for chemistry, physics, botany and zoology.

It might interest you that one of the four was Arthur Moody, who subsequently practised in Dunedin, and was for many years Chairman of the Hospital Board there. Fred Moody, our present Superintendent-in-Chief is his nephew.

When I went to Edinburgh at the beginning of 1907 the other three students continued their course in Dunedin.

During our year in Auckland we were allowed to attend the hospital. I suppose it was in keeping with the

older idea of apprenticeship, clinical work starting early in one's training. We never had any official instruction except from ward sisters, but we were allowed to examine patients, do some of the dressings, and watch operations.

The children's ward was on the ground floor of the Costley Block, and I think the sister in charge must have been very tolerant, for I remember doing dressings there several days a week. In those days there were many children with abscesses from tubercular bone infection such as psoas abscess, and dressings had to be changed daily. I have no doubt I did my share of increasing the mixed infection.

The verandahs of the hospital were open, and this applied to the Main Building as well as to the Costley Block. Beds were there permanently to provide the open air treatment of tuberculosis. Mackintosh bed covers and canvas blinds provided some protection in bad weather, but not much in an Auckland "*nor-wester*". The enclosing of the verandahs came only slowly because the Hospital Board, oddly enough, was even then short of money and had to meet an ever-increasing hospital population. Later special arrangements for TB cases were made with the shelters at Green Lane, and sanatoria at Cambridge and Waipukurau.

There were two theatres in use at Auckland Hospital in 1906. One was on the first floor of the Main Block opposite the Medical Superintendent's office. Here E.N.T. and eye operations were done. I remember vividly once going into this theatre when Hardie Neil was operating. The room was very dark and Hardie was working with a head mirror which reflected light from a gas lamp. I did not know that the lamp relied for its supply of gas on a rubber tube trailing across the floor. All I know now is that I walked into the theatre and the light went out. I heard the beginning of Hardie's comments, and then quickly, briskly, and I think wisely, trotted out.

Years later Hardie occasionally referred general surgical cases to me. Once we worked together in the excision of a pharyngeal pouch where he packed the pouch from inside with gauze soaked in acroflavine and I dissected it out from the outside, the bright yellow making the delineation of the sac wall easy. Hardie was a very original thinker. If my memory serves me aright the case was published in the very first volume of the *Australian and New Zealand Journal of Surgery*, but I never reminded Hardie of "*The Light that Failed*".

The Costley theatre was a single unit and it was in use every day, the honorary surgeons being Copeland Savage, Gore Gillon, and Tracy Inglis. The last named did most of the gynaecology, but I can remember watching him do the first nephrectomy I ever saw.

I also recall Gore Gillon wiring a fractured patella. This was of particular interest to me, because it had resulted from a hockey match in which I had been playing. Eleven members of the 'Varsity first fifteen had challenged the women's hockey team, and we all wore skirts — not mini of course, but right to the ankles in those days. This resulted in a series of accidents among the footballers, including the fractured patella. None of the girls was hurt, but three of us had to retire.

Both Inglis and Gore Gillon were general practitioners, but Copeland Savage was Auckland's first real surgeon. He had been on the staff of University College Hospital in London, and had come to New Zealand because of ill health. I presume he had early TB. He was a frail, lightly built man, but he got through a tremendous amount of first class surgery. It was during 1906 that he performed a resection of the Gasserian ganglion for intolerable neuralgia — the first in New Zealand.

I am sure that as I watched him doing this I did not realise who lucky this young colony was to have a general surgeon capable of performing an operation now left

entirely in the hands of the neurosurgeon. It was a very great tragedy, and a terrific loss to New Zealand, when he died of cerebrospinal meningitis in Egypt in World War I.

In 1906 the big buildings of the hospital were the old Main Block and the Costley Block, but there were some wooden huts scattered about. The Princess Mary and the Wallace blocks were not built until much later.

Opposite the Costley operating theatre there was a fairly big room, used chiefly as a staff room. Occasional meetings were held there, but its main function was to provide a locale for the surgeon's post-operative cup of tea. It was still being used for that purpose when I was a visiting surgeon. My father was in 1906 managing director of the Surgical Supply Company, which on his retirement merged with The Dental Supply Company to become Dental and Medical. One day Dr. Walshe, senior medical officer at the hospital, was in my father's office in Fort Street, and was told that the new Xray equipment had just arrived. "There are two big cases", my father said, "I'll have them sent up this afternoon". Dr. Walshe asked to use the phone, and sent a message saying that two heavy cases were coming up immediately, and that they were to be put in the staff room opposite the theatre. I believe that the matron was far from pleased when having had two beds put up in the staff room, and made arrangements for special nursing, the cases turned out to be made of wood.

I reached Edinburgh at the beginning of 1907, and passing the first professional, joined the students who had started their course the previous October.

Earlier on I indicated to you that surgery was primitive by the standard of today in that the use of surgical gloves was uncommon. Only one surgeon, Stiles, wore gloves, and then only when dealing with infected cases. This too was not for his own nor the patient's protection, but for the fear that he might carry infection to his next case. It was of course this risk, or rather this truth, that had led Lister to antiseptic surgery not so many years before. Using the old terminology Lister had shown that students coming from the dead-house to the lying-in wards were responsible for outbreaks of child-bed fever.

In those days of indifferent anaesthesia, it was thought particularly admirable to be a swift surgeon. There was still on the staff in my time a very elderly surgeon who had had a great reputation in his younger days, a reputation which was entirely based on his speed as an amputator. I don't think there was a Guinness Book of Records in existence then, but this surgeon held the record of 2½ minutes for amputation through the thigh. Presumably in his early days the anaesthetic of whisky plus opium made speed the essence of the contract. (I have been told that there was actually an earlier record of 33 seconds, but it was disallowed because the surgeon had also removed three of his assistant's fingers).

Of course speed was far less important in 1906, though because of the almost universal use of chloroform as an anaesthetic the length of time that the patient was on the table was important. It was recognised that any procedure taking over an hour carried extra risk. Perhaps it was because our clinical work still retained an essence of apprenticeship that students were instructed in anaesthetics early in their course. We were expected to be giving chloroform on open mask and without supervision by our third or fourth year.

Before leaving memories of student days I will refer once more to surgical gloves for in a way they indicate the progress of asepsis during my years of practice. In universal use before World War I, we never used them in the emergency surgery in France or Mesopotamia. They were universally used when back in Bristol doing orthopaedic work at the end of the war, and later of course in my years as surgeon at Auckland Hospital but with this limitation. Punctured gloves were repaired. I suppose this may sound very strange to you, but for many years it was the practice to fill our gloves with water when we took them off, and if a puncture showed putting the gloves into a special bowl for repair. If one had cause to go back to the theatre in the afternoon some member of the theatre staff would be found busily sticking little patches on gloves with rubber cement. Now of course you use anything once only, and even discard used syringes, disposing of everything it seems — except perhaps paper-work!

It is a long cry from the use of repaired gloves to all the principles of modern theatre asepsis, but I was interested to read in the very last *Annals of the Royal College of Surgeons of England* an article by Charnley, to whom I personally am so indebted for his work on hip replacement, for I have been mobile and pain free for the last eight years after three years of a two-crutch life. Charnley's theatre technique is, I believe, of the highest standard, and he writes of his latest advance — an absorbent bracelet of wool to prevent sweat running into his gloves from his forearms.

Now regarding a few of the outstanding advances in my lifetime. It has always seemed strange that advances before one's own time are so readily accepted, whilst those which occur in our own day never cease to amaze.

I mean that when I qualified it did not seem strange that smallpox was controlled by vaccination, or that heart disease was benefitted by digitalis, but I still wonder that diabetes is controlled by insulin, and pernicious anaemia by liver extract, and remain amazed at the marvel of the antibiotics.

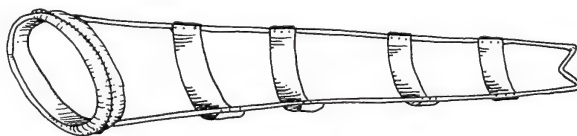
Perhaps the most important advance in my student days was the introduction of salvarsan. When 606 was first used we thought that syphilis would soon be of only historic interest. Of course so many great advances have been hailed in this way. 606 proved very toxic, and was soon replaced by 914 neosalvarsan. Even this was very damaging as I remember with shame. It may be good for you to hear the story.

Over the years it is of course inevitable that one makes many blues. I rather think that I have made my fair share, but perhaps they remain more vivid in old age than the cases that went well.

Anyhow, in using 914 I learnt a lesson that may be useful to you. As a junior house surgeon I missed the vein and injected the arsenic into the subcutaneous tissue of the elbow. Not a lot, but even after months of treatment the result was a permanently flexed elbow. Of course, I was to blame, but the point is the patient never bore me any ill-will, and even, will you believe it, finally told me that to have a stiff elbow was rather convenient to him! He was a London bus conductor, and in those days they carried a sort of leather tray on the left forearm with a collection of some twenty little piles of tickets from which the appropriate one was pulled off. His right arm was OK and his fixed left elbow carried the tray without muscular exertion. It was my first lesson in patient understanding and patient kindness. You'll meet it still I hope. Recognise it, but don't trade on it.

Another thing to remember too is that when you get blamed for something going wrong which you know you are in no way responsible for, don't worry too much; it is balanced by getting credit for work that deep down you know you didn't do too well.

The first World War came so soon after I had graduated; I had only done resident jobs in London and was working for my primary fellowship when war broke out. Naturally I went up to the War Office within the first few days, with the result that for my next six years I wore khaki. One looks back to the first year in France with horror. It was such destructive surgery. I wonder how many amputations through the thigh I did because a shattered knee joint meant either loss of life or loss of limb. Our great fear was gas gangrene. After a year in France I served a year in Mesopotamia where there was little infection of wounds but much tragedy from inefficient organisation of the transport of the wounded and an appalling loss of life from enteric diseases.



After a year in Mesopotamia I was invalided back to England, and served in one of the first orthopaedic hospitals established as a result of the persistence of Sir Robert Jones. Fairly early in the war, because of his great experience in Liverpool, he was given high rank in the R.A.M.C. and his insistence on the use of the Thomas splint for gunshot wounds with fractured femur had produced dramatic results. It is so far back that you may never have heard the actual figures.

Briefly, I can tell you that Sir Henry Gray, gathering statistics from the whole of the front in France, showed that in the first year of the war 80% of compound femurs died. Later Sir Anthony Bowlby recorded with similar material, that after the introduction of the Thomas splint the mortality had been reduced to 20%. Wonderful statistics! Would the air splint replace the Thomas splint now I wonder.

My years of practice in Auckland were from 1920 to 1960. Returning here some ten years after graduation, with much experience of war surgery and the orthopaedic branch of war surgery, but with no knowledge of peace-time orthopaedics, such as club foot, congenital dislocation and the damages left by infantile paralysis affecting the hip, I decided to follow the then generally accepted entrance to consulting surgery, of a few years' general practice. During these years the greatest advances in medicine were that insulin saved diabetics, and that liver extract made pernicious anaemia no longer fatal.

The importance of the pancreas in the aetiology of diabetes had been recognised for some time, although it was left to Banting and Best to make the crucial discovery of the importance of the islets of Langerhans.

When I was H.P. to Morley Fletcher at the East London Hospital for Children before World War I, he used to get me to go to a local butcher who did his own slaughtering, and obtain a fresh pancreas from him. What Morley did with it I have not the foggiest idea. He may have given it to his cook in Harley Street, but I was led to believe he used an alcoholic extract on animals bereft of their pancreas.

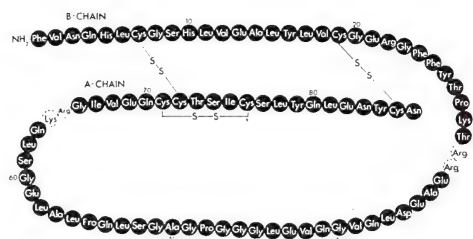
I wonder if you all realise that before insulin was available, severe diabetes in early life was universally fatal. I remember so well the death of a fellow house surgeon soon after we qualified. I met him one night walking down the corridor looking ghastly. I stopped him and asked what was the matter. He told me that he hadn't been feeling well recently, and that he had just tested his own urine and found it was loaded with sugar. We had a cup of coffee together and talked things over, but we both knew what was going to happen, and it did within six months.

It was in 1922 that supplies of insulin first reached England, and trials of its efficacy were first carried out. Dr. R.D. Lawrence in *King's College Hospital Gazette* wrote his personal story a few years ago.

He told how he, while a junior at King's, had been found to have severe diabetes, and been given a fatal prognosis. Dr. Lawrence was apparently very interested in Italian art, and he decided to go to Florence for the short time he was expected to live. While there he received a telegram from a colleague — three sentences: "I have insulin. It works. Come back quick." He did so and although nearly killed by too big a dose, he lived, and finally played a leading part in the founding of the British Diabetic Association.

It seems a very strange coincidence to me that after I had planned this lecture, and decided to relate this story of Dr. Lawrence, that I should read an almost identical case in the *B.M.J.* for June 4th of this year. It was in the obituary to a Dr. Muir-Smith who died last March aged 89. He had served in Salonika with the R.A.M.C. in the first war, and, returning to his practice in Eastbourne, was found to have diabetes, and like Dr. Lawrence was given a fatal prognosis. He was an old Guy's man, and when Banting came to England and set up a diabetic clinic at Guy's, Muir-Smith was given insulin. His obituary states that he also was a founder member of the British Diabetic Association, and that he must have given himself over 36,000 injections of insulin. In 1973 he received the Joslin medal as the first person in England to survive 50 years as a diabetic on insulin.

I often think that the immediate acceptance of



insulin by all doctors is a good answer to those critics who complain that we as a profession are reluctant to accept innovations. This charge against us is made only too frequently.

Almost annually a cure for cancer is claimed by someone. The fact that we do not accept it is said to be proof of our intolerance of anyone outside our closed community adding to our knowledge.

As a profession we are, luckily, sceptical. I have seen so many wonder cures rise dramatically, and then fade away. One such I remember so well because I was nominated by the Hospital Board to sit on a committee of investigation regarding a cure of rectal cancer. The cure had been given a lot of publicity in the local papers. Four members of the senior staff, under the chairmanship of the then pathologist, Dr. Walter Gilmour, had to spend long hours listening to how cancers had been evacuated per rectum after the administration of enemata of kerosene! It was obvious that the much to be pitied victims had suffered from bleeding piles, and after suffering more from their treatment, had sloughed and passed rectal mucosa.

Similar experiences will be yours as you go through life. At the moment apricot stones in Kansas City and something else in the Cook Islands are examples.

However, humanity still looks for miraculous cures, and remains extraordinarily gullible.

The miracle of my professional days was, of course, the introduction of antibiotics, and penicillin the miracle worker. We had only just got used to the sulfonamides, with prontosil as the leader, when penicillin burst upon the world. There was no hesitation about the acceptance of Fleming's work, but much delay in obtaining a supply, and at first it was very costly.

My first experience with penicillin was so dramatic that I will tell it to you in detail, for it must be difficult for you to visualise working without antibiotics.

In 1933 a little boy, three years old, was admitted to a medical ward in Auckland Hospital with a painful swollen left ankle. A diagnosis of rheumatic arthritis was made. Probably because of the unusual site, it was two or three days before osteomyelitis of the os calcis was recognised. He was transferred to a surgical ward, the bone opened and drained, and after some five weeks in hospital was discharged with a healed wound. I only mention the delay because this was the probable reason for the staphylococcus responsible remaining a danger to him for many years.

Within a few months of his first operation he was back in hospital with osteomyelitis of the lower end of his left humerus; with again an operation for drainage. My notes show that from 1934 to 1942 he was admitted to hospital 25 times, each visit necessitating my having to operate. Of course, some of these operations were sequestrectomies, mostly of the left humerus, but many other bones were involved at different times. These included both upper and lower maxillae, right scapula, once a vertebra, and twice ribs.

Then in 1942 he was admitted with osteomyelitis of the lower end of the right tibia. We knew of penicillin. We had none in New Zealand. The American Army had just established their hospital in Auckland. I happened to be Auckland B.M.A. president that year, and had got to know some of the surgeons, and appealed to them. They had none, but someone in the American Navy was flying some out for the new Naval Hospital. We got it.

Within two days of administration all signs of infection had disappeared, and what is more, there has never been another flare of the disease.

I met him some ten years ago when he sold me a ticket at a T.A.B. depot. His face showed three deep scars, and I suppose his body many more, but he was earning his own living with just one disability, an ankylosed left elbow. He is now farming in the Waikato.

This story illustrates so well how powerful penicillin was to the staphylococcus that had never met anything like it before. If only the staphylococcus had not soon developed a resistance, but it did, and soon there came a period when hospital cross infection occurred due to organisms that had developed a resistance to penicillin. Other antibiotics were only slowly being introduced, and hospital cross infection was common, leading to the use of the terrible phrase "H bug". With this came a public dread of hospitals, reminiscent of the pre-antiseptic era.

Slowly fresh antibiotics have been introduced with streptomycin leading the way against TB. In the last ten years that I was in practice I was able to keep abreast of these, and with sensitivity tests utilise the most effective. Now as I read surgical literature, I find antibiotics a list of strange names. You will have to learn their individual applications.

As I stress the discovery of penicillin as the greatest advance during my surgical lifetime, it is important to remember that there have been so many other changes that have together greatly improved our ability to help our patients.

Blood transfusion, now a routine in any major surgery with any blood loss. Dr. Jock Staveley is lecturing the Medical Historical Society in the near future on the development of the transfusion service during the years of his so capable administration. This should be very interesting, and he may tell you that before this time we relied on a group of twelve universal donors, organised with the assistance of St. John's Ambulance, who fetched the donors when required. You can realise that the need was great before a transfusion was given. We drew the blood from the donor into citrate and without any further testing ran it into the recipient. I recall only one tragedy from incompatibility, and I know lives were saved.

Anaesthesia, too, has been revolutionised from the days of the rag and bottle with chloroform and either given by a Schemelbusch mask. When I had charge of the children's ward and responsibility for dealing with cleft palates, it would be a case of working for a short time and then giving access to the anaesthetist for his turn. Looking recently at photos of these children, one realises that results were not those of the modern plastic surgeon, but one is still surprised that we were able to deal with these cases at all.

Microsurgery of the ear corrects some forms of previously irreversible deafness and this in turn has led to microsurgery in other fields, including the transplantation of organs and limbs.

And so I come to what is the great difference between the surgery of my day and that of the present. It is specialisation, and with this goes the years of postgraduate training.

When I was an assistant surgeon in Auckland in the 1920s there were no registrars. A phone ringing in the middle of the night might mean an acute abdomen, a patient unconscious with a head injury, a compound femur, a urological emergency, or even a Caesarean section. Obviously we had not had proper training in all these, and those of us who had spent the first World War in khaki were often forced to deal with conditions of which we only had book knowledge.

I remember being called for a Caesarean section one afternoon and running down the steps of my home in Symonds Street just as Casement Aikin, my next door neighbour, pulled up in his car. "Casement" I called, "I've got to do a Caesar — any tips, for I've never seen one?" "Yes" he told me, "Get hold of the kid and don't let go. They're very slippery!" I suppose I took his advice, for I know all went well. I suppose that although we were Jack of All Trades, we were only not the Modern Master of One.

After 50 years of practice, 40 of them as a general surgeon, I retired in 1961. The general surgeon now is only known in the isolated townships of the developing countries. Each of you who chooses a surgical life should be able to do one of my old jobs infinitely better than I

ever could, and this is just as it should be. Since my retirement I have watched the play of surgery for the last 16 years from the sideline, awaiting the final whistle.

You will already have accepted advances that still fill me with amazement. Coronary bypass and cardiac valve replacement are no longer news. It seems impossible to keep abreast of things, as we did, by reading journals and taking the occasional trip abroad. Luckily air travel makes "keeping up" more easily achieved.

May I finish on one word of warning. Do not allow specialised knowledge to interfere with general clinical examination and personal contact with your patient. Every disease is just part of a whole person. I am frightened of computerised medicine. Of course it is recognised that the elderly are conservative and easily frightened. It is the young that see visions. Computerised axial tomography is wonderful, but its use must not lessen clinical examination and the development of clinical acumen. Even in my last years of hospital I often felt that my house surgeons were depending too much on the laboratories and the radiologist.

All advance in our profession has but one goal, benefit to humanity and whatever branch you follow in later life, never forget the importance of the patient-doctor relationship. Develop and never lose the human touch.



The Dean's lectures take place weekly during the University term. They are given by people outside the faculty on subjects usually not directly about medicines, but of general interest. This lecture was the first of a centennial series organized by the Medical Historical Society.

What follows is a recorded conversation in which Eisdell Moore has been asked specific questions:

How did specialization develop in Auckland?

Specialization came about in a number of different ways. The repair of cleft palate and hare lip, a difficult problem, provides one example. Carrick Robertson had been responsible for dealing with these cases at first. When I took charge of the children's ward, they came under my care. My first results were not good, but improved when I had watched John Fraser in Edinburgh, whilst on a visit to Britain in 1930. He was professor of surgery and a general surgeon. Though not a plastic surgeon, he had a special interest in the surgery of children. As a student in Edinburgh, I remember him as a junior surgeon. We crossed the Channel together in 1915 on the way to the front.

Soon after Wellington Hospital appointed Dr. Pickering and his wife to be responsible for cleft palates in Wellington, arrangements were made for these two specialists to come to Auckland for a few days every month to deal with the Auckland cases. This was a sound move and I think it carried on until our own plastic surgery unit was established at Middlemore Hospital.

Then again specialization developed as each surgeon gave up dealing with certain cases, when someone else was getting better results. In the late 1930s ward 14 was shared by Kenneth Mackenzie, Frank Macky and myself, each with about ten beds. It just happened that a prostatectomy of mine was next door to a patient with similar trouble and under Frank Macky's care. Both patients were operated on in the same week. About a fortnight after, I came into the ward and noticed that the bed where Mr. Macky's patient had been was empty. I said nothing at the time. I rather feared the worst. As we

left the ward, I said to the sister, "What happened to Mr. Macky's patient?" and she said "Oh, he went home yesterday, perfectly dry, a complete success". Frank had been over to Australia, doing urological work there for a short time, and had come back with the very latest method of supra-public prostatectomy, and I thought it was just wonderful that the patient should be able to go out dry in two to three weeks. I always felt that prostate patients would be something like a month or five weeks in hospital. There and then, I decided that I would do no more urological work, and I said to the sister, "If I have admitted into any of my beds a patient for prostatectomy, tell my house surgeon that he is to arrange transfer to Mr. Macky's care". I dropped urological surgery, recognising Mr. Macky's special knowledge. He had become a urological specialist, the first in Auckland.

Can you comment on the relationship between the Auckland Hospital Board and the medical staff?

The Board and the staff were wrangling when I was a schoolboy, though I was too young to know the rights and the wrongs of the matters. Harmonious relations only came with the appointment of Dr. Charles Maguire, who served Auckland well from 1911 to 1932. Relations between the Board and staff are now good, but it was a long time before this happy state was brought about.

Control of the Hospital Board over the staff remained very strong for many years. I had been taught that canvassing for an appointment was unprofessional, and when I returned to New Zealand and applied to go on the staff as a surgeon, I refused to take the advice of various people and call on each member of the Hospital Board. In effect this appeared to me to be canvassing, which I regarded as unethical. Although holding high degrees, I was not appointed. Following this rejection, I applied for the medical superintendent's post at a country hospital. Again I was unsuccessful, and was later told by a member of that Board that this rejection was because I only had six letters behind my name — M.D., F.R.C.S. — and the successful candidate had eleven — M.R.C.S., L.R.C.P., L.S.A. — the last three letters standing for Licentiate of the Society of Apothecaries, being really of little value. In the long run I had to swallow my pride and visit each member of the Hospital Board before I obtained an appointment.

It was a long time before the Hospital Board accepted help from the medical staff. Finally, a Council on Appointments was established to make recommendations on the applications of physicians and surgeons every three years. There was not at that time any continuity of service. It seems strange to me that the first chairman of this Council on Appointments should have been Dr. Cyril Tewsley, who had suffered the termination of his own appointment by the Board to be replaced by someone far less skilled in the profession than he. Later I myself became chairman of the Council, retaining this position for many years after I left the staff of the hospital.

Have you any views on the composition of the Board?

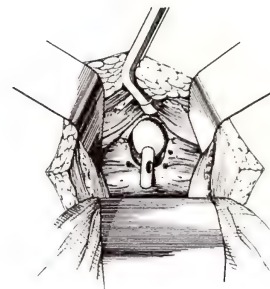
I have long considered that the responsibilities of the Hospital Board are too great for the election of all members by popular vote. Recently there has been opinion voiced that there are too many doctors on the Board.

I agree that if this occurred it would be most undesirable, and believe that, in view of the millions of dollars of annual expenditure by the Board, changes should be made to ensure that some financial and legal experts were Board members.

I consider that the Hospital Board should consist of:

- 3 Members nominated by the Auckland Branch of the New Zealand Medical Association.
- 3 members nominated by the Law Society.
- 3 members nominated by the Society of Chartered Accountants.
- 3 members elected by the public.
- 3 members appointed by the government.

This arrangement would surely give a balanced Board, more capable of dealing with the ever-present matters of priorities.



After retirement, do you miss the contact you had with former colleagues?

Had I retired at the present time, I should certainly have missed my colleagues, as so much information and experience is now exchanged in meetings, to discuss present advances, successes and perhaps more important, failures in our recent work. When I retired there was only the Auckland Clinical Society to meet that need. Socially I did miss association with my contemporaries.

When Dr. Sayers, (later Sir Edward) left Auckland to become Dean of the Faculty of Medicine in Otago, the Auckland Hospital gave an evening at which we made a presentation. It was an opportunity for those of us who had been on the staff for a few years to meet. We enjoyed it, and whilst I was talking to McGregor Grant and Geoff Fisher, we said how nice it was to have a chat together, as being off the staff, we no longer met; one of the three of us suggested that we might have a luncheon occasionally for all those doctors who had been members of the staff and were now retired. I know at that time most doctors were members of the Northern Club, and it was decided that we should have a regular lunch at the club. This went on for a few years, and we met once every two months. Gradually the members who constituted our first dozen or so died off. Very few young doctors now join the Northern Club. We got down to a number of perhaps only four or five, but Dr. McGregor Grant was very much averse to altering it in any way and making it open to consultants who were not members of the Club. Some time after he died, we decided we would make it open for anyone who had been appointed as a consultant by the Hospital Board. The number had grown, but we still have a luncheon at the Club once every two months, and I think everybody enjoys it. At the last one we had eighteen members, and we look forward to this as a tie among those of us who served the Hospital Board, though I think I am the only one remaining who was a member at the beginning. It has been a very pleasant way of keeping in touch with those who served as specialists. It was a purely social occasion, there are no speeches.

I feel sure that you, after listening to me rambling on in answer to your questions, would agree that the restriction is a wise one.

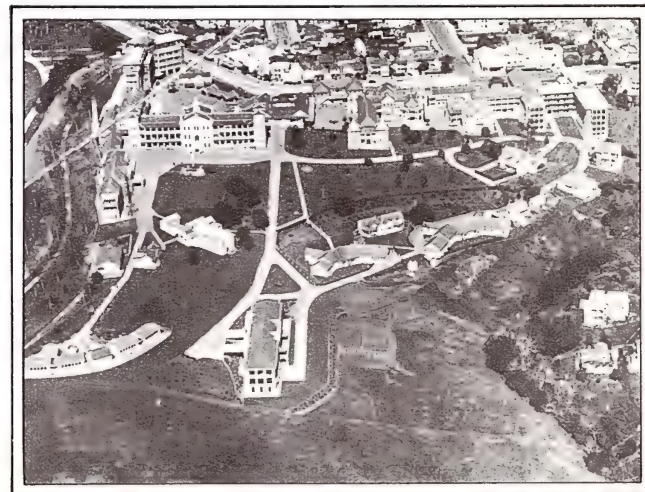


Fig. 23. The hospital as it was in the 1930s. The grounds are spacious and well cared for, and it is noted that the new border with the Domain is just beyond the Infectious Diseases Block. Further land was to be taken from the Domain to build the military annexe, now the Princess Mary Hospital.

NURSING IN THE OLD MAIN BUILDING IN THE 1940s

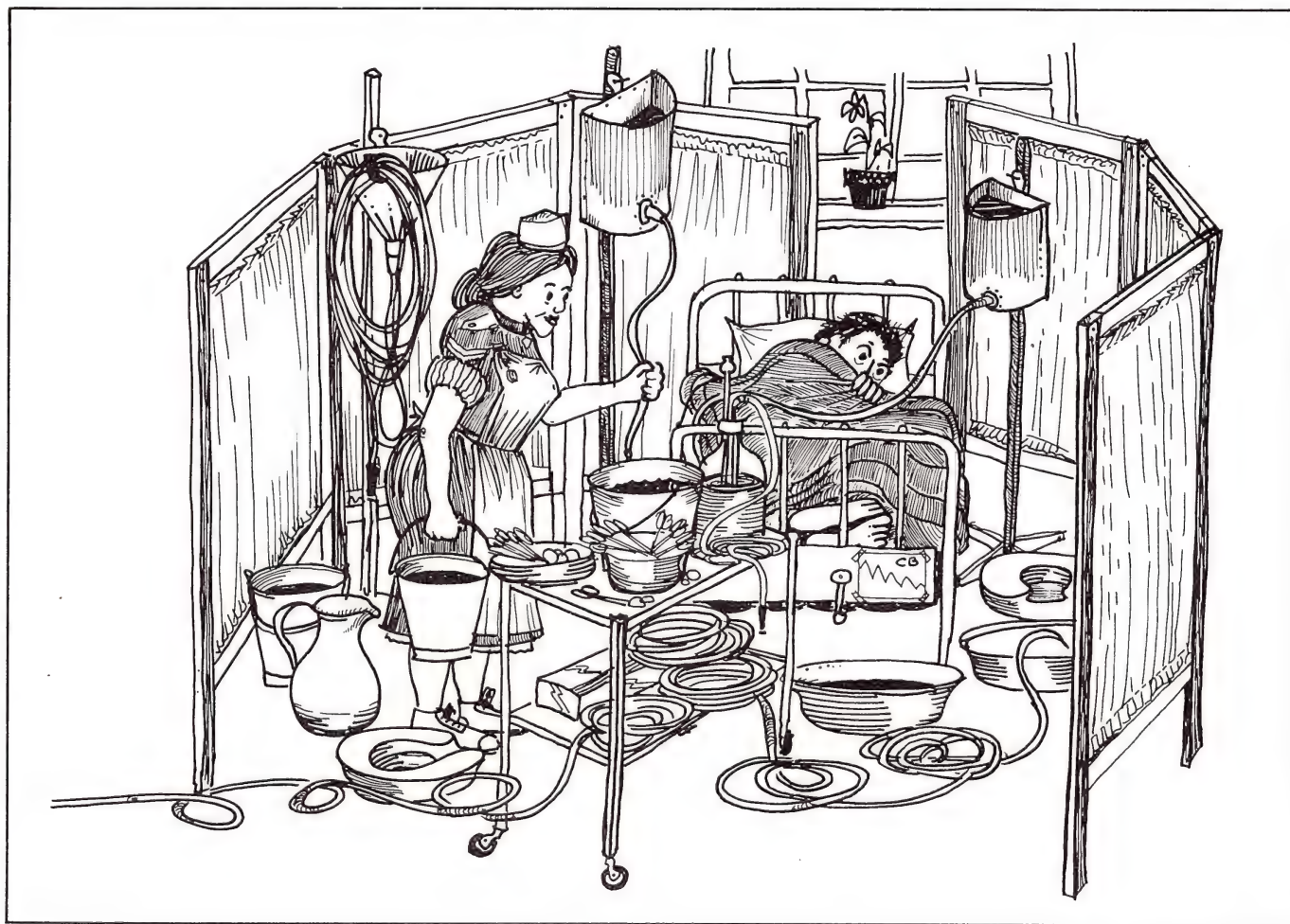
Thelma Bollard

Those nurses who worked in the old main building have rejoiced to see the magnificent new main building take shape. It replaced at one sweep all the inconvenient and antiquated arrangements with modern, well-designed facilities. However, to these staff, the old main building was hallowed by their long hours of duty, working together with the medical staff, fighting for the lives of their patients, sans i.v. fluids, sans antibiotics, sans respirators, sans artificial kidney machines, sans everything, except the applied skills and their combined professional knowledge.

The 1940s were still the days of external applications and internal irrigations. Plasters of antiphlogistine, mustard, linseed and glycerine and ichthyol — a tacky mess, were our stock in trade. The now scorned rectal drip saved many a life before the days of intravenous fluids. We certainly had to be cruel to be kind, when using subcutaneous drips to replace fluid loss. The senior probation nurse rejoiced in the title of the "Enema Queen", and she certainly earned her sixteen shillings and eightpence per week, administering the soap and water, olive oil, turpentine or molasses varieties to her unwilling patients. Her great lengths of rubber tubing, nozzles and gallons of water vied with the equipment of the local fire brigade. It was the afternoon junior probationer's first chore to make the soap jelly for the enemata on the gas ring in the sluice room or in the kitchen if the sluice room did not possess a gas ring. In her endeavour to get her afternoon washes over, she usually forgot the simmering cauldron, until an irate wardsmaid sallied forth to accuse her of making a soapy flood in the tidy kitchen. If Epsom Salts or Cascara at 6a.m. did not work by 4p.m., another name was added to the "Enema Queen's" list.

Before the advent of antibiotics, patients' cavities — rectal, vaginal, pelvic, abdominal, thoracic and bony — were all subject to irrigations of some kind, and the offensive results often equalled that of the Aegean Stables. It was before the establishment of the obstetrical and gynaecological hospital in Cornwall Park — later known as National Women's Hospital. This meant gynaecological and abnormal obstetrical patients were cared for at the Auckland Hospital. Patients requiring Caesarean section or gynaecological surgery went to wards 15 and 17, while pregnant patients with toxæmia, diabetes and the medical conditions went to ward 16 and its annexe, all in the Costley block. Wards 5 and 7 in the main building took gynaecological patients as well as general surgical ones. The old tower rooms, which had formerly housed the bathrooms and lavatories, had been converted into isolation rooms and they often contained one or two cases with septic abortion. It meant that the nurses assigned to these wards had more experience than desired in the techniques of administering douches and irrigations.

Medications were mainly in the fluid form — "Shake the Bottle Well" — so that drug dosage varied according to the conscientiousness of the nurses. In those war years the range of medications was not great. The good old standbys were Mist. Carminative, Mist. Expectorant, Linct. Camph. Co., Magnesium Sulphate and Mist. Bismuth. The advent of the early sulpha drugs made a great impact on diseases such as pneumonia. We were able to dispense with the pneumonia jackets of gamgee and the crisis was no longer dreaded. Good nursing care was still needed, but the new drugs annihilated the organisms. With sulphapyridine an unfortunate side effect was the cyanotic hue of the patients. This seemed to be minimized if onions and eggs



were excluded from the diet. By the mid 40s the miracle drug Penicillin arrived. Having tended and dressed osteomyelitis patients during their innumerable admissions, the effect of this antibiotic was miraculous. Mr. Eisdell Moore refers to it in his section. The advent of antibiotics changed many nursing procedures and dispensed with a host of time-consuming treatments, which were the traditional aids to the doctor's physic.

Our uniforms in those days were blue cotton, three buttons and of a simple style. The collars and cuffs of the short sleeves were faced with white. Seniority was denoted by a chevron on the left sleeve using sewn white tapes. In the excitement of the examination results, the carefully applied piece of sticking plaster was an effective way to denote 'I've passed'. White linen caps, styled to suit the wearer by ingenious pleating or gathering, were worn at various angles — on the back of the head — low on the forehead or atop the sausage roll hairstyle then in fashion. Black cashmere stockings and black shoes completed the uniform. White shoes and stockings were the status symbol of nurses who had achieved their fourth stripe.

The matrons of the 1940s were all very different personalities, but had in common a love of their profession and a determination to maintain a high standard of efficiency, even under difficult circumstances. Miss Emily Nutsey, affectionately known as 'Nut', left in the early 1940s with the Third Echelon of the New Zealand Army, to establish hospitals in the Middle East. She had already nursed in World War I and though over age, was appointed Matron-in-Chief of the New Zealand Army Nursing Service. Her outstanding war effort was the climax to a distinguished nursing career. She was Matron of Auckland Hospital from 1929, and throughout this long period proved a champion of her staff in negotiating better working conditions and educational opportunities for the profession. She introduced study days for the nurses and it meant the nurses had set days, devoted entirely to education and not just odd lectures through the working day, that a nurse may or may not get to, according to the work load in the ward. Another of her innovations was to send each year two to three sisters to the Postgraduate School of Nursing in Wellington, to further their education. Her efforts did much to raise the status of nurses from an inferior member of the health team to the more rightful place they occupy today. Though a strict disciplinarian, she was both loved and respected by her staff, because of her fairness and her championing of their rights. An example of her views would be her refusal to allow nurses wearing makeup to go on duty. They had to return to their rooms and remove the makeup at once. She occupied a lonely position and this was probably necessary at that time to maintain her authority and to achieve the goals she had set herself to improve the lot of her staff. When she left for the war, Miss Vera Cussen or 'Cuz' became acting matron, followed briefly by Miss E.M. Brown.

The duties of the assistant matrons during the war period included peering through the black-out curtained windows of the nurses' home to observe the goings-on under the pepper tree, a trysting place for the nurses and the Yanks of the U.S. Army service units camped in the Domain. We never discovered who ordered the sweeping boughs of the pepper tree to be shorn to a height of ten feet above the ground.

Miss Wynne Delugar became the lady superintendent in January, 1945. She proved a first class administrator during the early and difficult post-war years. Under her influence, the registered staff were to enjoy two whole days off each week. This innovation was not favoured by dedicated sisters, who thought the wards could not be run efficiently by anyone but themselves. When the Board was starting to rationalize the administrative needs of the four major hospitals in the Auckland area, with the creation of posts of the superintendent-in-chief and matron-in-chief, she was the obvious choice, ahead of many applicants for the latter post. At Board Office her flair for administration was put to good use. Even after retirement she continued to give excellent service to the community as a city councillor.

When Miss Delugar went to the Board office, Miss Leigh Talbot or 'Tal' took over the reins of the Auckland



Fig. 24. Queen Elizabeth II visits the hospital in 1953. This photograph, taken from the steps on the south facade of the old main building, shows her greeting Leigh Talbot, the matron of the hospital at that time. In the foreground is Winifred Delugar, the matron-in-chief, while John Grierson, the chairman of the Hospital Board, is waiting to introduce Mr. Bartley, a Board member, to the Queen. At Prince Philip's left is David Goodfellow, the medical superintendent. Leigh Talbot's father and her two brothers have been honorary medical staff at the hospital, while her two nephews have worked in the hospital as students and house physicians. The Talbot family would be one example of many, in which successive generations have served the hospital as doctors or nurses.

Hospital (Fig. 24). From her background as a splendid ward sister, she brought a depth of understanding and sympathy for the problems of her staff, facing up to the many difficulties of the post-war period. As one of her assistant matrons, I appreciated these qualities and her sense of humour, which relieved some of the tense situations. The baby boom accelerated the need for increased paediatric beds and the move from Princess Mary Hospital to the now vacant Military Annexe became necessary. Main building wards and the casualty department remained as busy as ever and the polio epidemics and the establishment of specialised units made increasing demands for more nursing staff.

The old casualty department (formerly Ward 2).

This department occupied the ground floor in the eastern wing of the building. The verandah was the waiting room and its entrance was from the north facade. Open cubicles served as dressing areas, a plaster area and a suture area. There were three curtained consulting rooms and a sister's office. The tower rooms were used, one for patients and one for the doctor's bedroom. Many a weary house-surgeon opened his bedroom door, only to find that his bed was occupied. Between the two tower rooms was a door opening out on to the ward 2 annexe, a barbaric out-house known as 'the cells'. The rooms had strong doors and small grilles. To these rooms we admitted on a temporary basis alcoholics and other patients in various states of dementia. Between the cells and the main building was an alleyway, used frequently by the hospital service trucks. There were some near misses, as nurses dashed from the casualty department in answer to the summons bell. The bunch of keys and the small wire grilles, and the noise of those poor patients will remain in the memories of many of us. The conditions of the annexe frequently hit the headlines in the daily newspapers, until a much improved observation unit was created down the hill in old Ward 10.

During the war years many general practitioners were overseas or in military camps throughout New Zealand. This created a considerable pressure on the depleted staff in the casualty department. The sister in charge, Violet Hyde, fought hard to retain capable nursing staff, so that a competent student nurse was

retained for six to nine months, at the expense of gaining experience in the general wards. These nurses developed considerable skill, particularly in suturing and plasterwork, because of the shortage of doctors. With all the nurses living in, they gleaned a great deal of knowledge from one another, as the dramatic events of each duty were exchanged over supper or during exhilarating walks up Mt. Eden or through the Domain bush — pleasures which meant much to a generation that had little money and no transport.

Patients with minor injuries or those requiring hot soaks, sat at a long bench waiting their turn for the glycerine and Mag. Sulph. dressing, collodion bandage or application of previous Mercurochrome (£5 per small bottle). It seemed to us that a number of patients came for the entertainment value, such as watching the application of a finger bandage or the setting of sterile trays. This last procedure called for considerable practice and skill. One had to cope with faulty sterilizers with scalding water spurting out under an ill-fitting lid, or a leaking outlet. A burn on the forearm was a nurse's badge. The Cheatle forceps often had sloppy hinges and worn jaws, so that many a bowl was lost in mid-air, necessitating a return to the sterilizer for a further five, ten, fifteen or twenty minute boil, whichever was "correct" at the time. Most of the bowls and kidney dishes were of old chipped enamel. The setting of these dressing trays was a chore made more difficult as the "approved technique" was altered by the tutorial school every year. To secure the items for a respectable tray, the nurse had to take second place to a staff-nurse, setting a tray for the one and only doctor. The night nurse in casualty spent a good part of her duties trying to clean these enamel trays, bowls and kidney dishes with a mixture of sandsoap and Lysol. With such a powerful corrosive, it was no wonder that these nurses were frequently sent over for emergency treatment at the eye department. It seemed ironical to me that after battling for years to get all wards equipped with stainless steel, the disposable era came upon us, rendering all this beautiful and new equipment obsolete.

With casualty department acting as an outpatient department for the anaemia clinic and other clinics, innumerable injections were always being given. At that time only glass syringes were available, requiring sterilization between use. Matching the barrels with the correct pistons and needles with the right nozzle caused us great frustration. To avoid losing the needles in the sterilizer, we placed them after cleansing in the soap-shaker. A request to the stores office for a certain type of needle always elicited the same reply — that the shipment was lost in a boat sunk in convoy on its way to New Zealand.

In those long duties in casualty, it always seemed to me that half the Auckland adult population possessed varicose ulcers. While these patients were meant to attend the Skin Clinic in the basement of the Wallace building, a number of strays always found their way to casualty, and a duty never passed without a nurse being asked to apply an Unna's paste bandage. This involved soaking an impregnated bandage, and when the right squelchiness had been obtained, it was applied as quickly and as expertly as possible from the toes to the knee. One had to be sure that it was the right temperature, to avoid buring the area.

Violet Hyde left the Casualty Department to become matron of the Cornwall Geriatric Hospital, and Lillian Hawkins "ran" the department followed by Jean Kinnear until 1950, when Megan Wynne took over the charge position, where she reigned for 17 years. Of all the trained nursing staff of the hospital, there would be no-one more in the public eye and coming in touch with more people, albeit from certain sections of the community, than those sisters in charge of the Casualty Department. Their tasks called for special qualities, both in handling the patient and guiding the resident medical staff.

Ward 3 for male surgical patients.

Situated in the western wing of the first floor, it was of the Nightingale type, as were all the big wards in the main building. It was comprised a long and open room with nine beds on each side, and in each tower at the far end there were one or two beds for infectious cases. A

centre-press or table with cupboards beneath, took pride of place in the middle. One side of the press held the pills and potions and the other the lotions, while the poison cupboard was perched at one end, usually with a vase of flowers on the top. Some small drawers on either side of the lotions cupboard spilled their contents of T badages, Vees, theatre caps and long, thigh-length woollen theatre socks on to the floor. With medicines in this situation, it was not uncommon for the honorary surgeons on their ward rounds to have to circumnavigate a charge nurse on her knees, while she dived to the back of the cupboard for the Mist. Carminative. The ward sister's office consisted of a table, either just inside the door of the ward or between the tower rooms at the end of the ward. In one situation she lost all the papers off the top of her table in a merry fluttering dance, each time the ward door was opened. In the other situation she had to walk the full length of the ward to speak on the telephone or to relatives waiting anxiously at the ward door for advice about their loved ones. The ward sister's sitting room was a tiny area opposite the kitchen at the entrance to the ward. Here the medical and nursing staff had morning and afternoon tea and supper, the staff going in two by two as the room was so small. It contained a large store cupboard and a sash window which we usually couldn't open. The window adjoined the work room of the main

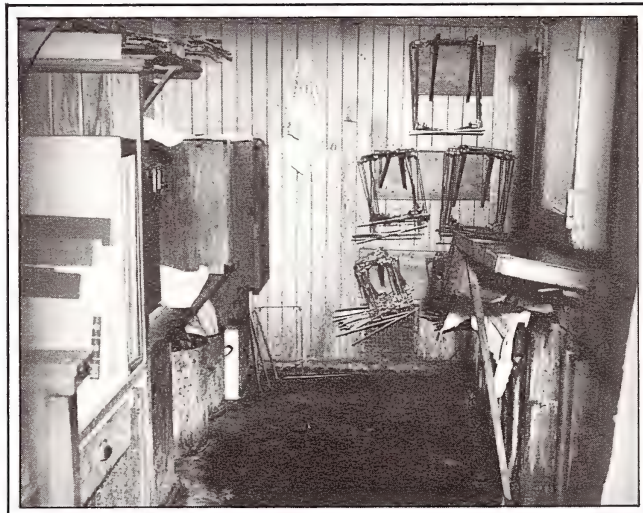


Fig. 25. The dark room in the old Xray Department alongside Casualty. This is a far cry from the automatic film processors and clean and hygienic conditions under which radiographers work in the new building. In the 1930s radiology was still very much in its infancy, and at that time there was simply not the money available to spend on the service departments, and what little there was went towards maintaining decent standards in the ward and patient treatment areas.

building theatre. It was impossible to enjoy afternoon tea in company with a loop of gangrenous bowel on full display in a large kidney dish across the way. The service rooms in the main building were incredible. The facilities were extremely poor, and to maintain good standards, under these difficult circumstances, required meticulous technique and a great deal of hard work. The first four or five beds on either side of the ward, closest to the sister's desk, contained our sickest patients, being only just admitted or just back from surgery, or struggling with some complication. The whole ward shared their sufferings.

I have varied memories of ward 3, the earliest being during the depression years, when it was a female surgical ward and I was a patient there. I have vivid recollections of coming out of a rag and bottle anaesthetic and hearing an afternoon junior pro doing the round of her patients. She was resplendent in a mauve and white striped uniform, stiffly starched and wearing black shoes and black cashmere stockings. "Poached or boiled?" she inquired of all the patients for their preference for the evening meal, because it was always an egg either way. In those days there was no social security, and hospital finance was restricted and meals were meagre, and patients paid for their hospitalisation. Part of the medical

superintendent's duty was a daily round of the ward pig tins to see that there was no waste. My experience as a patient in this ward came in useful when I became the sister there many years later, working with the two honorary surgeons, Frederick Furkert and Alan Spedding. As sister, I followed Bess Brodie and Grace Gordon, who was later to become the matron of Green Lane Hospital. The ward was not equipped with a refrigerator until 1949, and then it had to be put in the corridor leading to the ward, with the empty bottle crates alongside, lying in ambush to trip up passers by. Prior to this arrangement, the wide window sills served as cool stands for large buckets of milk and their dippers, covered over with wet gauze to keep them cool.

Ward 3 never seemed to be without beds down the middle. These beds made any procedures extremely difficult, both for the patients in the extra beds and the patients on either side. We used cumbersome, rather heavy wooden-famed bedside screens, and these added to the obstruction. At Christmas time you could usually reckon on the ward emptying out somewhat, and I well remember one Christmas when the nurses and I went ahead with an elaborate scheme for decorating the ward. We made dozens of beautiful roses from crêpe paper. One nurse with an ingenious turn of mind suggested we tape them to the white, wooden intravenous drip-stands,



Fig. 26. Conditions in the old boiler house, which heated the hospital till 1968. Frank Tanner, the man who provides the steam, is taking a break in his eight hour shift as boiler attendant. He is watching the gauges of the Babcock and Wilcox boiler, which is out of sight on his left. Behind him is the main switchboard of the boiler house, on a wall which is cement-rendered clay. Instructions for the shift are on the board. The tunnel behind the seagrass chair carries the steam to the Wallace Block, and still functions with the new boiler house. Discarded ward furniture provide a modicum of comfort. Note his method of keeping his second cuppa warm. In his earlier days, Frank Turner always carried a copy of the award for boilermen and firemen, and he enjoyed challenging the engineer at that time, Frank Pegler, on points of contention. In the foreground are the well-polished handles of his wheelbarrow, with which he removed the ashes and fed coal into the hopper of the semi-automatic feed system.

The situation is typical of the conditions under which many staff members worked the greater part of their lives to keep the hospital going.

which we were going to set at intervals at either side down the ward, to give the effect of a wonderful avenue of standard roses, so we thought. Then, alas, the admitting officer rang. In quick succession, patients with perforated ulcers, accident victims and other emergencies flooded in. The roses were whipped off the drip stands and replaced by Abbott bottles of intravenous fluid, which by this time had replaced the primitive douche cans and drips of earlier year. That year we had to forgo the usual ceremony of the honorary surgeons carving the roast chickens, all patients being on intravenous fluids.

Even in 1949 early ambulation was still not accepted by the surgeons. The honorary on one side of the ward was a strong advocate and would insist that his

patient was out of bed the day after a herniorrhaphy. His more conservative colleague on the other side of the ward would have his patient immobilised for three weeks. We began to realise the folly of the Fowler position, maintained by a bolster made up of a pillow tightly wrapped in a drawsheet. It was placed under the patient's knees and anchored to the head of the bed. With a pile of pillows at his back, it kept the patient upright to allow drainage from abdominal wounds through the stiff corrugated rubber drains and the Penrose tubing. This bolster restricted movement and impeded the venous circulation of the legs, often with disastrous results.

Most patients after major abdominal surgery had a Wagensteen apparatus set up. To this was added underwater drainage and an intravenous drip, so that yards of rubber tubing were required for each patient, and it was hard to come by at that time. Any patient unlucky enough to develop a paralytic ileus was subjected to the passing, or our attempts to pass, of a Miller-Abbott tube, everyone having fun and games with the balloon, except the patient.

Ward 4 — the male surgical ward.

Jessica Lynds was looking after the ward at this time. It housed men from the local military camps. Most of these patients had been put in hospital either for herniorrhaphy or tonsillectomy, to render them fit for military duty. The tonsillectomy cases were operated on in the Wallace theatre. It was the duty of the nurse on divide to be responsible for these theatre cases, and she spent half of her duty riding backwards and forwards across the desert to the Wallace theatre in the ambulance.

The desert was so-called because of the large open area between the main building and the Wallace block. In the middle of it stood a solitary Phoenix palm. As successive old photos show, this tree grew with the years, although once it was partially destroyed by fire, when sparks from the nearby hospital kitchen chimney ignited the numerous bird nests concealed in its leafy top. In those days there was no recovery room and the patients returned to the wards still under anaesthetic. It was amazing that no major catastrophies occurred, although there were plenty of scares at the time. Air raid drills with the emergency evacuation of patients also took place in the desert.

Ward 5 — female surgical ward.

During the 1940s Hilda Willoughby, Leila Robertson and Peg Whyte were looking after this ward. This was on the top floor of the main building at the western end. It contained a great variety of surgical cases, as it was before the days of specialized hospitals and units. Women with severed tendons, brain injuries and tumours requiring craniotomies, and a great deal of gynaecological and obstetrical conditions such as ruptured ectopic pregnancies, provided us with great drama. Auto-transfusions in theatre were often life-saving in those early days of blood replacement.

When Leila Robertson had this ward, it was a reflection of her capabilities and good taste. Her curtains, jug covers and runners on the centre-press were constantly being admired. She was a superb organizer, so that patient care in this ward was of an extremely high standard. She seemed to find time to do appliqué work on bed linen. Every piece was marked with the ward number, hand embroidered in red cotton by the afternoon and night nurses, when they had 'nothing else to do'. I well remember one set of curtains in a tower room in this ward. They featured blue yachts in full sail appliquéd on a white background and were very attractive. They had been stiffly starched and ironed by the night nurse. All ward sisters were responsible for their own linen repairs. Prior to the advent of the envelope type of pillow-case after the war, pupil nurses must have sewn on thousands of tapes to pillow-cases during their training.

Leila Robertson was on hand at the crash of the DC8 at the Mangere Airport and was most effective in providing first aid at that disaster.

On the top floor of the main building in the other wing was Ward 6, a male surgical ward similar to Ward 3. In charge of this ward was Judy Downie followed by Jean Guthrie, now the principal nurse at Middlemore Hospital.

Ward 7.

Yvonne Beaumont was in charge of this ward. Originally this had been a small fever ward and then it later accommodated the nurses' dormitory, but in the 1940s it was a female surgical ward, sandwiched between 5 and 6 and immediately above the main building theatre. I well remember as a very junior nurse in 1942, in my haste to get all my washes done before breakfast, I slipped on a patch of wet linoleum, to crash-land. I dropped two large enamel bowls, two enamel tooth bowls, two tooth mugs and all their contents as I fell. To make matters worse, I knocked over the cumbersome wooden drip stand, to which was attached a precious intravenous drip in a sterile enamel douche-can, covered with a theatre guard. I was severely reprimanded. It was just as well that surgery had not yet begun in theatre below, as such a commotion would have marred the surgeon's concentration and the atmosphere of the operating session for the rest of the morning. It was a major task for the charge nurse to set up an intravenous drip trolley. With the exception of the suture material, all the equipment was prepared for use in the ward. The bowls, forceps, needles and cannulae were arranged in regimental fashion on a Nightingale trolley and covered with sterile guards and pronounced ready for the doctor. The morning charge nurse was also responsible for the following day's supply of gauze swabs and dressings. These were produced from basic supplies of large cotton-wool rolls and gamgee tissue. Frequently this task was incomplete before the nurse had to dash off to a lecture, hoping the door would not be locked before she got there. After sleeping through the lecture, she would then dash back to the ward to finish her stock-making. With two large white bags-full, looking like the proverbial Santa Claus, she would make her way across to the Costley Block, to toss her precious bundles through the open windows into the sterilizing room, with a sigh of relief. On arrival back in the ward, her relief would turn to a groan of dismay, as a great flood of water from an overflowing sterilizer would often greet her. It always took so long to fill, but as soon as one's back was turned, the inevitable happened. There was nothing but to remove one's shoes and stockings and set to with drawsheets, counterpanes and cuddly-rugs to soak up the water. To restore the area to dryness, before being caught by the sister, created an inward glow of satisfaction, known only to those who have been in this predicament.

The Main Building Theatre.

In this there were two operating tables, separated by a movable screen, permitting a major and a minor operation to take place simultaneously, or for the operation to be going on while the next case was being anaesthetised. They often placed a piece of towelling over the patient's eyes before he was wheeled into theatre, to spare him the shock of seeing the other operation taking place. Somehow the towelling usually fell off. Rubber gloves were in very short supply during the war years, and nurses spent many hours washing, drying, mending,

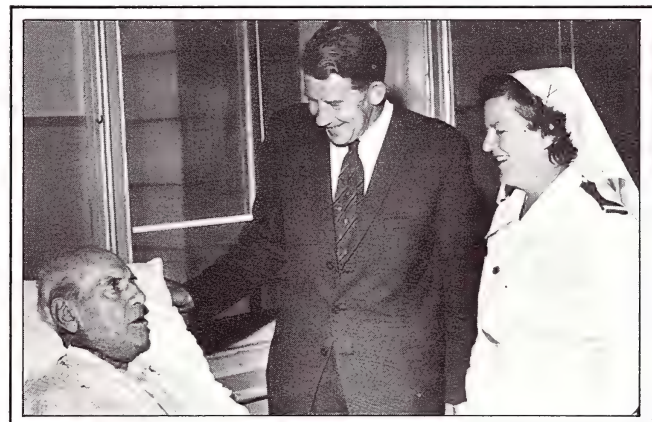


Fig. 27. Thelma Bollard, assistant matron and David Goodfellow, medical superintendent, farewelling the last patient to leave the old main building prior to its demolition. David Goodfellow's geniality and patience were invaluable attributes while the hospital was coping with the introduction of specialist units and their need for space, successive poliomyelitis epidemics and the initial planning for the new hospital and School of Medicine.



Fig. 28. A newspaper photograph of some of the hospital sisters taken outside the steps on the north facade of the old main building, just prior to its demolition in April, 1964. The narrow steps are worn by the traffic of 87 years of use. From left to right are:-

Megan Wynne, who reigned in the Casualty Department for 17 years, Thelma Bollard, then acting matron, but previously sister in Ward 3, Marjorie Burton, supervisor of the Infectious Diseases Block, Bess Brodie, sister in the X-ray Department and previously a sister in Ward 3. Dorothy Grace, home sister, Amy Ryan (now Rothery) a former sister in Ward 14 and at the time supervising sister from the Board Office.

powdering and packing gloves for autoclaving. On the sunny stairway outside the theatre on the north facade, there was an apparatus of row upon row of dowels, upon which we dried these gloves.

Space does not permit me to describe the other 26 wards of the hospital. Each had its unique architecture, set of patients and common diseases and special nursing tasks. It was rather scary walking around the hospital at night under war-time blackout conditions. The babies in wards 24 and 25 on the upper floor of the physiotherapy and radiotherapy block, were fed at night by runners from the other blocks. Going up to the original Princess Mary Hospital for children, we often got soaked in the wintry weather. It was our usual practice to shut ourselves in the kitchen, whip off our uniforms and dry them out in the steam-press. Many of the soldiers in the military annexe — the present Princess Mary wards — were full of high spirits, sometimes induced by a hidden bottle. After the rigours of war, some leniency in discipline was understandable. Wheelchair and spinal-chair derbies, starting from the main building, would gather momentum down the hill, swirling around the corner to pass 33 and on to the finish outside the brick infectious diseases' block.

The period 1940 to 1950 saw great changes in medicine and nursing, many accruing from the experience of the war. The decade saw the establishment of intravenous fluid therapy, blood transfusion, antibiotics, new vaccines, early ambulation of surgical patients and a host of mechanical aids. To my mind, the use of curtain rails suspended above each bed, with the abolition of those heavy wooden bedside screens, and the replacement of enamel-ware with stainless steel bowls and kidney trays were noteworthy achievements too. In this period the recovery of the patients was more hard fought and won than in the present day. Working in wards that were ill-planned and inconvenient was hard work, though not drudgery, because of the rewards we gained in the eventual recovery of our patients, and because each procedure and treatment involved material and equipment prepared within our ward by our own efforts. As we were all living in at that time, the trials and triumphs and humorous incidences of the day were all shared.

In the 87 years that the walls of the main building stood, with countless patients passing through its portals, aided by generations of staff members, it seemed wrong to demolish it over a few days with such ease. Just as the introduction of new remedies and procedures was inevitable, the old building had to go. With its demolition we lost the substance of the past, but we must hold on to the spirit and strength of those early days (Fig 28).

The old main building stood on the hill-top in 1877 with two small companions, the original hospital of 1847, known as the "upper refuge" with the "lower refuge" of 1851-52. The "lower refuge" was first occupied as a lunatic asylum until 1867, when the new asylum was provided at Avondale. With the completion of the old main building, these refuges were used for the obstetric care of destitute women and for the aged and infirm poor. In 1890, with the completion of the Costley Home — the original building on the Green Lane Hospital site, and still extant, the patients in the refuges were transferred there and these two oldest hospital buildings were deliberately destroyed by fire. The old main building then stood alone; it was the Auckland Hospital.

Gradually over the next 87 years, satellite buildings accumulated on the 17 acre site. Some were of permanent construction — the kitchen (1896), the Costley wards (1898), the medical superintendent's residence (1904), the Costley theatres (1905), the nurses' home (1911), the original Princess Mary Hospital for Children (1918), the Wallace Block (1923) and the Infectious Diseases Block (1931). The remainder were temporary, of wooden construction, each erected on an *ad hoc* basis to meet a special need, such as growth of population, an epidemic or the return of sick and wounded servicemen from the second World War.

By the mid-1950s the old main building had earned its title: it was still the largest of 51 buildings on the site. In the eyes of the medical profession and the public it was still "The Auckland Hospital" — (the 'The' was seldom

omitted), despite the fact that it was only part of a very much greater whole which constituted the Auckland Hospital complex. Meanwhile growth of major and minor peripheral hospitals had reduced the once all-sufficient Auckland Hospital to the position of being one of four major and 14 minor hospitals under the control of the Auckland Board.

In the 1950s, proposals for the demolition and replacement of the old main building met a mixed reception. Past and present staff of all categories regarded the building with pride and affection despite its deficiencies. It was still serving its original function as a general hospital with solely general medical and surgical beds and out-patient and casualty departments. The X-ray Department on the ground floor had outgrown its limited accommodation and was now located elsewhere in a "temporary" building.

In 1958, long before authority for demolition was granted from the Department of Health, the Auckland Hospital Board had commissioned a "programme of requirements and a schedule of accommodation" for a new main building. This was written by Mr R.F. Galbraith, Secretary of the Board, who was closely concerned and indefatigably industrious in the planning and building of the new block until his retirement in 1968 (Fig. 29).

A new building cannot be expected to have a history of its own on the day of its completion. Its history,



Fig. 29. Ray Galbraith, from the Auckland Hospital Board and Warwick Smith from the firm of Stephenson and Turner, architects, discussing the layout of a section of the new building. In November, 1959, the Department of Health authorised the Board to prepare "A programme of planning requirements" for a "main Auckland Hospital of 640 beds and service departments", and for Stephenson and Turner to assist in this. Ray Galbraith, the secretary of the Board, was appointed secretary of the planning committee and prepared the programme, working with Warwick Smith, who had been seconded by the architects. The latter had just returned from a five year period in the U.S.A., where he had been working on the development and the design of modern hospitals and medical schools. After full collaboration with representatives of all the departments and services, the 141 page programme was completed, approved by the Board in July, and by the Health Department, with minor exceptions, in November, 1960. With authorisation to instruct the architects to proceed with the planning, Warwick Smith assembled a team of architects and engineers to design the new building and the planning of the detailed requirements of individual services and departments. Ray Galbraith, until his retirement in 1968, acted as co-ordinator at the innumerable meetings with small groups of hospital staff concerned with the planning of their own areas. By 1968 the interior planning and the outside structure of the entire building was completed for stages 1, 2 and 3, with stage 1 ready for occupation. The co-ordinator for the final requirements of stages 2 and 3 was Ron Lockie, the assistant secretary of works for the Board.



Fig. 30. Some idea of the rubble walls and plaster finish of the old main building may be had from this photograph. The ease with which the building was destroyed in April, 1964, indicated the devastation an earthquake could cause. For all its inconvenient and antiquated arrangements, many of the old staff were tearful as they watched its demolition. The building was hallowed by the long hours of duty and the experience of successive generations of staff during the 87 years the building served the public of Auckland.

The inset photograph shows Kerry Burcher, visiting surgeon, and Wilton Henley, superintendent-in-chief, watch a two ton "monkey" demolishing the western end of the building. The old hospital, built over two years and completed in 1877 at a cost of £25,000 was demolished in two days at the cost of £7130.

such as it is, is the sum of all that has gone before. It is, however, of interest to consider the influences which prompted the Auckland Hospital to seek authority to demolish the permanent old main building and to proceed with the planning of a large and costly replacement. After initial ministerial reluctance, authority for the demolition was granted by the then Minister of Health, the Honourable Mr. Skelton, in 1963.

To the many influences which prompted this decision, the condition of the old main building itself must have contributed. It was difficult of access above the ground floor, having one central wooden staircase and one slow-motion lift. The wards were poorly designed for their function. A single operating theatre had no change rooms or anaesthetic rooms. The plumbing was primitive. The building was an horrendous fire risk. The ease with which the building was subsequently demolished indicates that it could not have withstood an earthquake. The building, built over a two year period at a cost of £25,000 in 1877, was demolished by a "monkey" on a crane in two days at a cost of £7,130 in 1964 (Fig. 30).

The quality of work in hospitals depends, not on buildings, but on the morale and competence of staff. Old main building had known an abundance of good work in its past years. However, the standards of the past were rapidly changing. Other hospitals, built or building, were providing a new environment for advances in medicine in Auckland. The medical staff of Auckland Hospital were seeking the same standards of excellence.

Advances in medicine and surgery since World War II were among the foremost influences contributing to the decision to demolish old main building. Auckland Hospital, originally a general hospital, was now a general hospital with specialties. In medicine, wards for infectious diseases, paediatrics and psychiatry occupied satellite buildings on the site. In surgery, special units of neurosurgery, urology, oncology, ophthalmology and ear, nose and throat surgery were similarly scattered. Other specialties had been established in peripheral hospitals mostly acquired or developed since the war. Green Lane Hospital housed special departments of chest medicine, cardiology, thoracic, cardiac and peripheral vascular surgery, and ear, nose and throat surgery. Middlemore Hospital had all the Auckland Hospital Board's Orthopaedic and plastic surgical facilities. Cornwall Hospital and, later, National Women's, Middlemore, St. Helen's, North Shore and Waitakere and smaller peripheral hospitals provided for obstetrics. Half of Cornwall Hospital housed geriatric patients. In all hospitals, but particularly at Auckland Hospital, the rising demands for space for laboratories and X-ray Departments created major problems in themselves.

Though it was obvious that a new building at Auckland Hospital could not accommodate all special departments, it could bring together in one building most of the special departments already scattered on the site. It was notable that, with the exception of old main building, the Costley wards, the nurses' home and the Wallace Block, few of the satellite buildings were being used for the purpose for which they had been designed and built. The Princess Mary Hospital for Children now contained the radiotherapy and physiotherapy departments. The Military Annexe, built after World War II for returned servicemen, was now the children's hospital. Accommodation for orthopaedic patients now housed patients with infectious diseases. Wards built on an *ad hoc* basis during epidemics were now general medical wards or part of the nurses' tutorial school. A ward built to accommodate tuberculous patients now contained the psychiatric unit. Another became the "medical centre" for meetings and conferences. Its ground floor provided the headquarters for sixth year medical students of the Branch Faculty of the Otago Medical School.

In planning the new building, the Auckland Hospital Board was aware that there had been a progressive and revolutionary change in medical staffing, training and competence during the 87 years of service of the old one.

In 1876, the medical staff were general practitioners. Though some were appointed as honorary surgeons and some as honorary physicians, one as an ophthalmic surgeon and one, later, as a bacteriologist, all

had received the same basic training for a qualifying degree or diploma and few, if any, had any post-graduate training in specialties.

Between 1910 and 1940 most hospital doctors had practised as general practitioners or military surgeons for some years and then, having saved some money, proceeded overseas to acquire postgraduate qualifications. They returned as general physicians and general surgeons, some with a major interest in a specialty such as dermatology, paediatrics or chest medicine, others with special training in orthopaedics, urology, neurosurgery or obstetrics and gynaecology.

Between 1940 and 1950, the staff recruited during or after the war had a different background. Most had had war service and had proceeded or remained overseas after the war, impecuniously, to obtain postgraduate qualifications. They returned as specialists with a background of military medicine quite different from the generalist experience of their predecessors. The physicians were mostly all-rounders: the surgeons mainly general but with increasing diversion into sub-specialties. It is of interest that there were not sufficient specialist physicians in New Zealand during the war to staff the military hospitals with the forces overseas. New Zealand had to "borrow" from the Royal Army Medical Corps.

From 1950 onwards, the pattern of training changed again. After 1952, the Medical Council of New Zealand imposed a year of obligatory pre-registration experience in hospitals. Most would-be specialists took advantage of the postgraduate training now available in Auckland. Many spent four years or more as house men and registrars and gained a postgraduate diploma of one of the Australasian Colleges. Most then proceeded overseas, many helped by a postgraduate study grant from the Department of Health, and obtained further experience in a specialty in paid jobs for which their postgraduate qualifications made them eligible. They returned to New Zealand as specialists in sub-specialties eight years after qualification. Some were still generalists though most had a special interest. The rest were cardiologists, chest physicians, gastroenterologists, neurologists, paediatricians, neonatologists, rheumatologists, nephrologists, psychiatrists, endocrinologists, dermatologists, geriatricians, physicians in physical medicine, in infectious disease, in nuclear medicine or in medical engineering. There were still some general surgeons, though the field of their activity was shrinking because of the differentiation of ear, nose and throat surgeons, ophthalmic, orthopaedic, plastic, thoracic, cardiac, peripheral vascular, paediatric, urological, renal transplant, neurosurgical or gynaecological surgeons.

The simple pathologist of the past was now either a morbid histologist, a microbiologist, a virologist, an immunologist, a clinical biochemist, a haematologist, a neuropathologist, a cytologist or a forensic pathologist.

Anaesthetists were now specialists confining their activities entirely to this field. A few general practitioners retained anaesthetics as a field of special interest. Radiologists, diversified among their own sub-specialties, were no longer simple reporters of films. A wide range of subtle and complicated investigative techniques were now within their competence. Nuclear medicine had become a specialty; its techniques required expensive equipment and special protective screening.

The Auckland Hospital Board was aware that each of these specialties and sub-specialties required beds, out-patient departments, space and equipment for new investigatory and therapeutic techniques. The simple hospital building of 1876 could not cope with the demands of medicine of the mid-twentieth century.

A change had also occurred in the remuneration and conditions of appointment of medical staff. Honorary staff, aware only of a voluntary obligation in their relationship with the Hospital Board, continued into the 1940s. A small stipend was introduced in the late 1940s: finally, all staff were paid a full salary or tenths of a full salary on a sessional basis.

Another change which the new super-specialisation had prompted was a great increase in the number of whole-time staff of specialist status. In addition, a spectacular increase in the number of registrarships provided opportunities for training the staff



Fig. 31. Otago sixth year students undergoing final year training in Auckland in 1955. Seated in the front row is Edward Sayers, as sub-Dean of the Auckland Branch Faculty. At the time he was an honorary physician at the Auckland Hospital. He later went on to become Dean of the Otago Medical School. Seated alongside him are the two tutors, David Rogers in Surgery and Michael Gilmour in medicine. Both are still on the staff of the hospital in a visiting capacity. Immediately behind Edward Sayers is John Scott, at present a professor in the Department of Medicine, while above him is Roger Greenhough, the deputy medical superintendent of the Hospital. Elsewhere in the photograph are Lawrence Smith, William Tucker and John Richards, who are on the staff of the Auckland Hospital or School of Medicine. The students in this group have gone on to become general practitioners and specialists scattered throughout New Zealand and overseas.

The staff of the Branch Faculty since 1938 and the Auckland Hospital since 1927 have performed a valuable task in training Otago sixth year students in the more practical aspects of medicine.

of the future.

Probably the greatest influence which prompted the Auckland Hospital Board to plan on a grand scale for the future was its hope that the Auckland Hospital would, one day, be a focal point of the clinical years of students of an Auckland School of Medicine.

There had been talk of a medical school in Auckland as early as 1883. The only evidence remaining was an anatomist's licence, the Philson Trust and the David Nathan Trust. In 1888 Mr David Nathan gave to the Auckland Hospital and Charitable Aid Board, on trust, the sum of £200 for the giving of lectures "for the instruction of medical students". The money rested, accumulating by compound interest, until 1962 when the annual interest exceeded the amount of the original gift. The interest has since been used for the purpose intended.

In 1938 the Auckland Hospital Board accepted a Branch Medical Faculty of the University of Otago for the education of sixth-year medical students in the Board's hospitals (Fig. 31). The introduction of whole-time salaried directors of medicine and of surgery at Auckland Hospital was resented by and proved unacceptable to the Honorary Visiting Staff. The appointments of the distinguished incumbents, Dr Charles (later Sir Charles) Burns and Mr Maxwell Clarke, were terminated after a short period.

In 1950 a different spirit prevailed. The three senior physicians of the Auckland Hospital, at an informal meeting, resolved that the developments in medicine were "going past them so fast" that every effort should be made to encourage the training and appointment of younger men. This attitude was to culminate in the formation, in 1958, of a "Medical Unit" headed by a whole-time physician, Dr J.D.K. North, seven years after qualification. He now holds the first chair of medicine in the Auckland School of Medicine.

Earlier, the Auckland Hospital Board had also accepted the Postgraduate School of Obstetrics and Gynaecology which was temporarily housed in Cornwall Hospital till the building of the National Women's Hospital. Later, when the original planning of the new

National Women's Hospital had been shown to be inadequate for the needs of the professorial unit, the Board built a complete floor of professorial offices and research laboratories on the roof of B block of the hospital.

In 1952, the Senate of the University of New Zealand set up the Gibbes Watson Committee "to look into the future of medical teaching in the Dominion and, particularly, to advise whether or not a second medical school should be set up in Auckland." In 1953 this committee expressed the opinion that the Auckland school should be in active operation in 15 to 20 years from the date of its report. The committee also recommended that planning for the medical school in Auckland should commence forthwith.

At the instigation of Sir Douglas Robb, the first step was taken in 1957 by the Auckland Medical Research Foundation. Dr Wendell Macleod, then Dean of the Medical School of Saskatchewan, Canada, was invited to visit Auckland to advise on medical research and education.

Following this visit, the University of Auckland set up a Steering Committee on Medical Education. This was a strong committee combining academic, hospital board, medical and lay influences at top level (See Appendix C).

A deputation from the Steering Committee waited on the then Prime Minister, the Right Honourable Walter Nash, seeking an assurance that the second medical school in New Zealand would be sited in Auckland. In a letter dated 31 July 1959 the Prime Minister reported a decision by Cabinet to the effect that "when a second medical school is planned for erection it will be in the city of Auckland."

Submissions, prepared by the Steering Committee, were tendered by the University of Auckland to the Hughes Parry Committee on New Zealand University affairs in 1959. The subject of a second medical school was dismissed "without serious consideration."

Nothing loath, the Steering Committee commissioned a report by Dr John Cairney, recently retired ex-Director General of Health. In October 1960, Dr Cairney presented a report on the establishment of a medical school, first in temporary buildings, as had been



Fig. 32. Sir Douglas Robb with the executive committee of the Auckland University Medical Students Association in 1971. The group of third and fourth year students are from left to right – John Goldsmith, John Kerr, Wilma Grant, Innes Asher, Sir Dougals, Peter Charlesworth, Rowan McNaughton, Paul Ockleford, Beverley O'Keefe and John Faris. These students, entering their clinical years, were the fruits of a long and difficult venture – the establishment of the School of Medicine in Auckland. It had its beginning with the hopes of the early Auckland Hospital medical staff, such as Thomas Philson, and was consummated by the efforts of the Steering Committee on Medical Education, led by the indomitable Douglas Robb. One can imagine his pride and sense of achievement in being with this group of students.

successfully achieved in Perth, West Australia. The report was submitted as an appendix to submissions by the University of Auckland to the University Grants Committee in March 1961.

No success was achieved. In October 1962, the University of Auckland sent to the University Grants Committee "The case for urgency" – a submission prepared by the Steering Committee. The University followed up this submission with a strong personal delegation in December 1962. The case was rejected.

By 1963, others had joined the fray. The New Zealand Hospital Boards' Association reaffirmed its opinion, expressed two years previously, that there was an urgent need for the school. The Special Committee on the Availability and Distribution of Medical Practitioners issued an interim report in favour of the immediate establishment of the school. The Dean of the Medical School in the University of Otago, Sir Edward Sayers, though rejecting some of the arguments, agreed with the setting up a school in Auckland, indicating that the Otago School would be glad to reduce its intake of medical students.

A further submission "Reiteration of the case for urgency in the inauguration of the proposed medical school" was made by the University of Auckland to the University Grants Committee on 22 June 1964. At last there came a chink of light at the end of the dark tunnel of six years of unsuccessful submissions. At the request of the University Grants Committee, the Auckland Hospital Board agreed to second its Medical Superintendent in Chief, Dr W.E. Henley, to act as advisor to the Grants Committee and the Government with the following order of reference: –

"(a) To undertake such investigations and negotiations as are necessary to establish a medical school at the University of Auckland in an appropriate relationship with the Auckland Hospital system.
(b) To report to the University Grants Committee on the above matters and any others considered relevant to the development of medical education in New Zealand."

The then Medical Superintendent of Auckland Hospital, Dr D.R. Goodfellow, graciously accepted the position of acting-Superintendent in Chief and his deputy, Dr Alec Warren, took over the superintendency of Auckland Hospital.

I was seconded as advisor to the Grants Committee from 15 December 1964 to 15 August 1965. During this

eight months I prepared a series of reports as a basis for discussion by interested parties. These were circulated variably to Senate Advisory Committee of the Academic Implications of the Medical School, to the Senate and Council of the University of Auckland, to the interim Joint Relations Committee between the University and the Auckland Hospital Board, to the Steering Committee on Medical Education, to the combined staff of the Auckland hospitals, to the Postgraduate Medical Committee in the University of Auckland, to the Medical Council of New Zealand and, all of them, to the University Grants Committee.

Special surveys were conducted on "Standards of Medical Education in New Zealand" (at the request of the Medical Council of New Zealand), on postgraduate educational facilities in Auckland, on medical research in New Zealand and in Auckland and on medical library services.

By June 1965, sufficient progress had been made to recommend the appointment of a Dean of the School of Medicine so that further discussions on a University-Hospital Board level might be preceded by negotiations between the Dean and the Superintendent-in-Chief. Professor C.W.D. Lewis was appointed as Dean on 13 August 1966 and took up his duties in February 1966.

From this moment the School of Medicine was really afloat. Intensive effort by the University of Auckland enabled temporary and permanent accommodation to be made available in 1968 for the first intake of medical students proceeding to a degree of Bachelor of Science in Human Biology. Meanwhile the new main building of Auckland Hospital was already well advanced in planning and building and the Auckland Hospital Board was able to assure the University that the hospital would be ready, in part, for the first intake of clinical students in 1971. The western half of the new building was formally opened by Her Majesty the Queen in 1971.

The recommendation of the Gibbes Watson Committee of 1953 had been made a reality. Though many helped in this achievement, the Chancellor of the University of Auckland, the late Sir Douglas Robb, (Fig. 32) formerly a cardiothoracic surgeon at Green Lane Hospital, had been an irrepressible, indomitable (O.E.D. = "stubbornly persistent") driving force throughout. Under his chairmanship the Council of the University of Auckland and its Steering Committee on Medical Education had refused to take "No" for an answer.

Credit was also due to the Auckland Hospital Board which, under the chairmanship of Mr John Grierson and Mr T.H.C. (later Sir Harcourt) Caughey had anticipated, promoted and provided in advance for the school of medicine in the Auckland and other hospitals. The Board had also participated in the battle for the site of the school. Newmarket rate-payers, particularly one, took every possible step to prevent the building of the school on the site in Park Road opposite the hospital. Some of this dilapidated residential area was owned or leased by the Board and had been reserved for the Blood Transfusion Centre. The Board surrendered its interests and built the Blood Transfusion Centre in Park Avenue. Eventually, when all protests and appeals had been heard, the University took possession of five acres and the building of the first stage of the pre-clinical block began. A tunnel under Park Road connected the hospital with the school and allowed the hospital boilers to provide steam for heating purposes (Fig. 33).

Though the schedule of requirements had been written and plans made for the accommodation of academic units in the new Auckland Hospital ten years previously there was still an opportunity for alterations when the School of Medicine became a reality. The suites for the Professors of Medicine, Surgery and Psychiatry provided ward and out-patient space, offices for professors and their medical and clerical staff, seminar rooms and a lecture theatre for 100 for teaching and ample space for well equipped research laboratories. Temporary buildings for neurophysiology and head injury cases were built attached to the Princess Mary Hospital for Children with the intention that when the departments of neurology, neuro-physiology and neurosurgery were

united in the eastern half of the new main building these would remain as academic space for the Professor of Paediatrics until the new children's hospital, long in prospect but slow in realisation, was built.

The action of the Auckland Hospital Board in providing space for research in the new main building was in advance of the authority at the time. The Hospitals Act 1957 gave authority for research only in National Women's Hospital. In 1960, after the establishment of medical units in the sub-faculties of the Otago Medical School, some relaxation of this restriction was allowed for certain hospitals which housed academic units. But no money from Vote Health could be spent on research.

In 1956, the late Mr John Grierson, then chairman of the Auckland Hospital Board, distressed and possibly resentful at the small amount of funds coming to the Auckland area from the Medical Research Council of New Zealand, sponsored the formation of the Auckland Medical Research Foundation which was generously supported following a public appeal for funds. In 1962, as a member of the Medical Research Council, I invited the Council to hold its meeting, the first ever in Auckland. A display at the National Women's Hospital section of Cornwall Hospital indicated that the proscription of research in Auckland hospitals was more honoured in the breach than the observance. There was evidence of 72 research projects in the major hospitals of the Board.

The Hospitals Act 1957 was subsequently amended to permit Hospital Boards to house research in "existing accommodation" and to give heat, light, power, fuel, laundry, cleaning and accounting services "free" to approved research projects. The research space in the new main building of Auckland Hospital, in sum a complete floor, was already far enough advanced to come into "existing accommodation". The interest of the Auckland Hospital Board in the furtherance of medical research in

hospitals was later exemplified by the appointment of its chairman, Mr T.H.C. Caughey, as chairman of the Medical Research Council of New Zealand.

The Auckland Hospital Board was similarly forward-looking in the provision of library facilities to meet the needs of growing specialisation and the academic aspirations of its medical staff. Provision for a library was first made in 1883, when Dr. Philson donated the retirement funds given to him by the public of Auckland in gratitude for forty years of devoted service and stipulated their use for the establishment of a library "for the medical studnets of Auckland". The Philson collection is now housed in the library of the School of Medicine which, appropriately, bears his name.

In 1950, the only library in the Auckland Hospital was a few books and journals in a small room in the laboratory of the Wallace Block. This was then expanded and moved to the lower ground floor of the nurses' home. In the original schedule of requirements for the new main building, 5,000 square feet had been set aside for a medical library. Such space proved unnecessary when, in February, 1960, Sir Ernest Davis offered to build the Marion Davis Memorial Library in memory of his wife and to endow it with £100,000. Space was found on the only suitable fragment of land on the Auckland Hospital site, and the completed building was handed over in June, 1961. The Auckland Hospital Board provided the foundations of the building and continued generous supplements towards the running costs. Now re-named the Ernest and Marion Davis Library, it has a sizeable collection of books and takes 730 periodicals a year. It is a model hospital library which works in close collaboration with the Philson Library in the School of Medicine. It still houses the "Cathedral Collection" of Bishop Selwyn's medical books.

From the foregoing it can be seen that the Auckland Hospital Boards of the last 30 years have indeed been effective partners with the University of Auckland in its academic aspirations for medicine. After the School of Medicine had been established and the Auckland Hospital had been prepared to receive its students there still remained the problems of University-Hospital Board administrative liaison. Between 1964 and 1970, as the new main building grew to its full height, discussions continued between the Auckland Hospital Board on administrative matters per medium of an "interim Joint Relations Committee."

In 1963, Sir Harold Himsworth, Secretary of the Medical Research Council in the United Kingdom, visited New Zealand to advise on the constitution and research activities of the New Zealand Medical Research Council. He recommended, "with no reservations", that certain hospitals should be recognised and formally designated as Teaching Hospitals and that each Teaching Hospital (or Teaching Hospital group) should have its own governing body, separate from the Hospital Board for a district.

In considering the subject of University-Hospital Board administrative liaison, the Senate Advisory Committee of the University of Auckland did not follow Sir Harold's recommendation but reported that "for teaching purposes we envisage using an integrated Auckland Regional Health Service". This implied that all hospitals were "teaching" but, in addition, the services in the community of the Extramural Hospital, of the local Department of Health and of general practitioners would also be involved. This concept was a measure of the maturity of medical attitudes in Auckland. Medicine had thrown off its sense of colonial dependency and was planning to develop the present local conditions rather than to yield to a slavish imitation of past English patterns.

This concept, functional rather than administrative, was, mercifully, accepted by both the Council of the University and the Auckland Hospital Board. If battle had been joined early in the negotiations to abolish the traditional role of the Hospital Board, to create a new governing body (appointed rather than elected) or, as the University of Otago did later, to seek the appointment of representatives of the University on an otherwise elected Hospital Board, the Auckland School of Medicine would not have got off the mark in 1968 (Fig. 34). Dr Christie, Dean of McGill Medical School visited Auckland later,

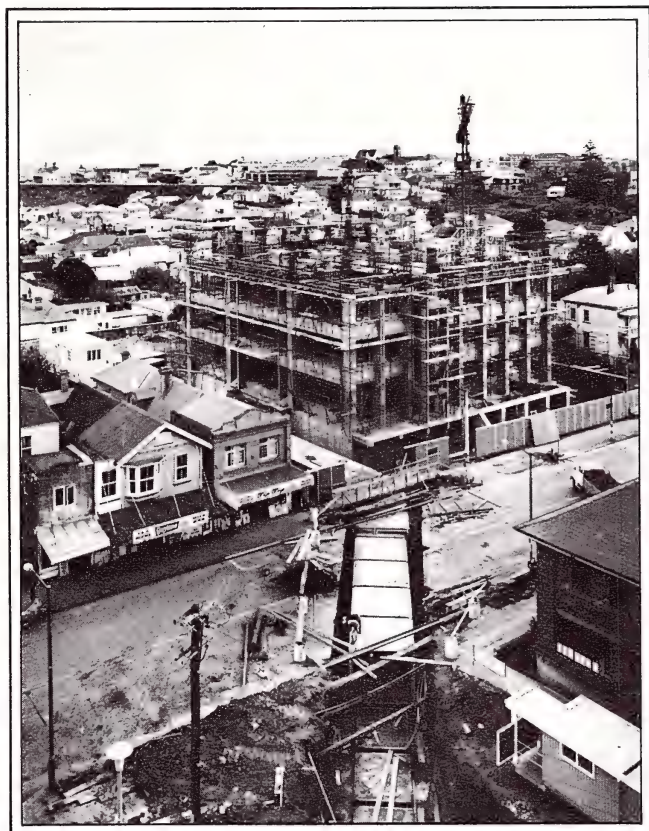


Fig. 33. The tunnel under Park Road in the course of construction. It was made of prefabricated inverted U sections. The excavation and laying of the tunnel was carefully planned to interrupt traffic for a very short time. The tunnel provides a pedestrian link for students and staff between the School of Medicine and the Auckland Hospital. It also carries a steam line to the School of Medicine from the boiler house on the Auckland Hospital site. Telephone and computer cables are also housed in the tunnel. The system links with a tunnel running parallel to Park Road, giving the nurses access to their various homes, including the new one on the corner of Park Road and Grafton Road.



Fig. 34. The first class of medical students in the new School of Medicine in Auckland. The photo was taken during their first year at the university in 1968. Cecil Lewis, the Dean of the School is in the centre of the front row. On his left are John Duder, Graham White and Peter Jenkins, lecturers in Physics, Physicochemistry and Biology respectively. On Cecil Lewis's right is the first president of the Auckland University Medical Students Association, Wilton Henley. As the superintendent-in-chief of the Auckland Hospital Board, he was worked for many years to establish the School and forge practical relationships between the Hospital Board and the University of Auckland, and between the School of Medicine and the Auckland Hospital.

After graduating in 1972, many members of this original class became house physicians in the Auckland Hospital, some of them now holding registrar positions.

after advising the University of Otago on development and administration of the medical school. He readily conceded that the size, scope, conditions and attitudes in Auckland were different from those of Otago so that what was right for one was not necessarily right for the other. The University of Auckland and the Auckland Hospital Board, already long-term partners in the advancement of the School of Medicine, concentrated on cooperation and compromise within the existing legislation.

One problem requiring solution was that of "joint staff". In Dunedin staff were employed by the University for teaching and by the Hospital Board for service. All went well until the time for sabbatical leave arrived. The University salary continued but the Hospital Board portion was limited to leave of three months. It was agreed that in Auckland all medical staff should be classified as either University staff or Hospital Board staff but not as both. While staff of each category might have both service and teaching commitments, each individual should have only one "master" and one, instead of two sets of conditions of appointment — forms of advertising of vacancies, procedures of appointment, leave and methods of payment. A member of University staff was defined as one giving at least half ($\frac{5}{10}$) of his or her time to teaching, a Hospital Board employee as one giving less than half ($\frac{4}{10}$ or less) of time to teaching. In practice most full-time University staff give $\frac{5}{10}$ of service sessions and most Hospital Board staff give $\frac{1}{20}$, $\frac{1}{10}$ or more, up to $\frac{4}{10}$ of time for teaching. Initially, the University pays for the service contribution of University staff and the Hospital Board pays for the teaching contribution of its own staff. The amounts paid by each for the other are reviewed at regular intervals and a payment is made, either way, to reconcile any disparity.

The Auckland Hospital Board recognised the interest of the School of Medicine in the choice of hospital staff to positions in hospitals in which undergraduate students receive their clinical training. The composition of the Medical Advisory Committee and the Board's Council on Appointments was adjusted to include adequate academic representation.

In the past, Joint Relations Committees with the University of Otago set up in Auckland under the provisions of the Hospitals Act 1957 had been solely advisory to Board and Council. They had no executive authority. However, the legislation provides for Board, Senate and Council to have the authority to delegate, with specifically defined exceptions, their powers to committees consisting of their own members or others. A proposal was put forward and accepted that the Joint Relations Committee of the Auckland Hospital Board and the University of Auckland, being itself a committee of both Board and Council, should be given executive authority in certain matters of joint concern. After considerable discussion (since the extent of delegation was greater from the Board than from the Council) it was agreed that the Joint Relations Committee should have delegated executive authority in relation to the appointment of Hospital Board medical staff, the confirmation of service commitments of University staff and the teaching commitments of Hospital staff, the granting of special leave, the consideration of applications for study grants for junior hospital medical officers and the approval of research projects on hospital premises.

The interim Joint Relations Committee was finally replaced by a definitive Joint Relations Committee in an agreement between the Auckland Hospital Board and the University of Auckland which was signed by the contracting parties. It received the approval of the Minister of Health on 23 July, 1970. Since this time this agent of joint administration has served its purpose admirably. There are no proposals for change.

The performance of a hospital depends more on the people who work in it than on the form of its buildings. Good work can be done in poor surroundings and bad work in perfect conditions. Nevertheless, the excellence of the new main building of Auckland Hospital cannot but inspire all who work in it. The building is so vast that no brief description can do it justice. It is indeed a fitting partner for a School of Medicine of infinite potential.

The architects for the new main building came from the firm of Stephenson and Turner, an Australian and New Zealand firm of great experience in the planning of hospitals. The first preliminary sketches for a new block at Auckland Hospital were prepared by Mr. Donald Turner in September, 1936 (Fig. 35). The proposal envisaged the demolition of the old main building and the Costley Block. The Auckland Hospital Board's commitment with the first new main building at Green Lane Hospital at the time caused what was thought would be a temporary deferment of further action. However, with the coming of World War II, the plan for the development of the Auckland Hospital was postponed. After the war the windfall of 700 beds in former military hospitals at Middlemore and Cornwall reduced the urgency for the extension of the Auckland Hospital. In the 1950s the Board began making new plans and in November, 1957 the Department of Health approved Stephenson and Turner being appointed to prepare a development plan on the Auckland Hospital site. In November of 1959 the Department agreed that Stephenson and Turner be

appointed architects to assist the Board in bringing forward a programme of requirements for all stages of the development of the Auckland Hospital. This programme of requirements and a schedule of accommodation was issued in July 1960 and, after minor amendments, the Department of Health authorised the preparation of sketch plans.

Stephenson and Turner have always worked in a collaborative type of practice. It is never possible to say precisely who was responsible for any project. The project architect for the firm in the building of the new Auckland Hospital was Mr Warwick Smith but he had the assistance of other architects including Sir Arthur Stephenson himself who determined the outside colour of the building and the fenestration. Throughout the contract Warwick Smith had a quiet manner, an infinite patience, and a quintessence of tact which concealed a firm guiding hand. He could not be belittled, as Mr Herepath had been at the opening of the old main building in 1876 by being "argued out of his opinion by gentlemen of greater experience in such matters than himself".

Architectural opinion is that the building is, functionally, too small: 50,000 square feet of needed accommodation could not be included in it. From a townscape point of view the building is too large. When its bulk and dominance were realised Sir Arthur Stephenson wrote to the Auckland Hospital Board expressing his worries on this score but the Board decided that it was too far committed to withdraw at this stage.

The plans for the new building were necessarily

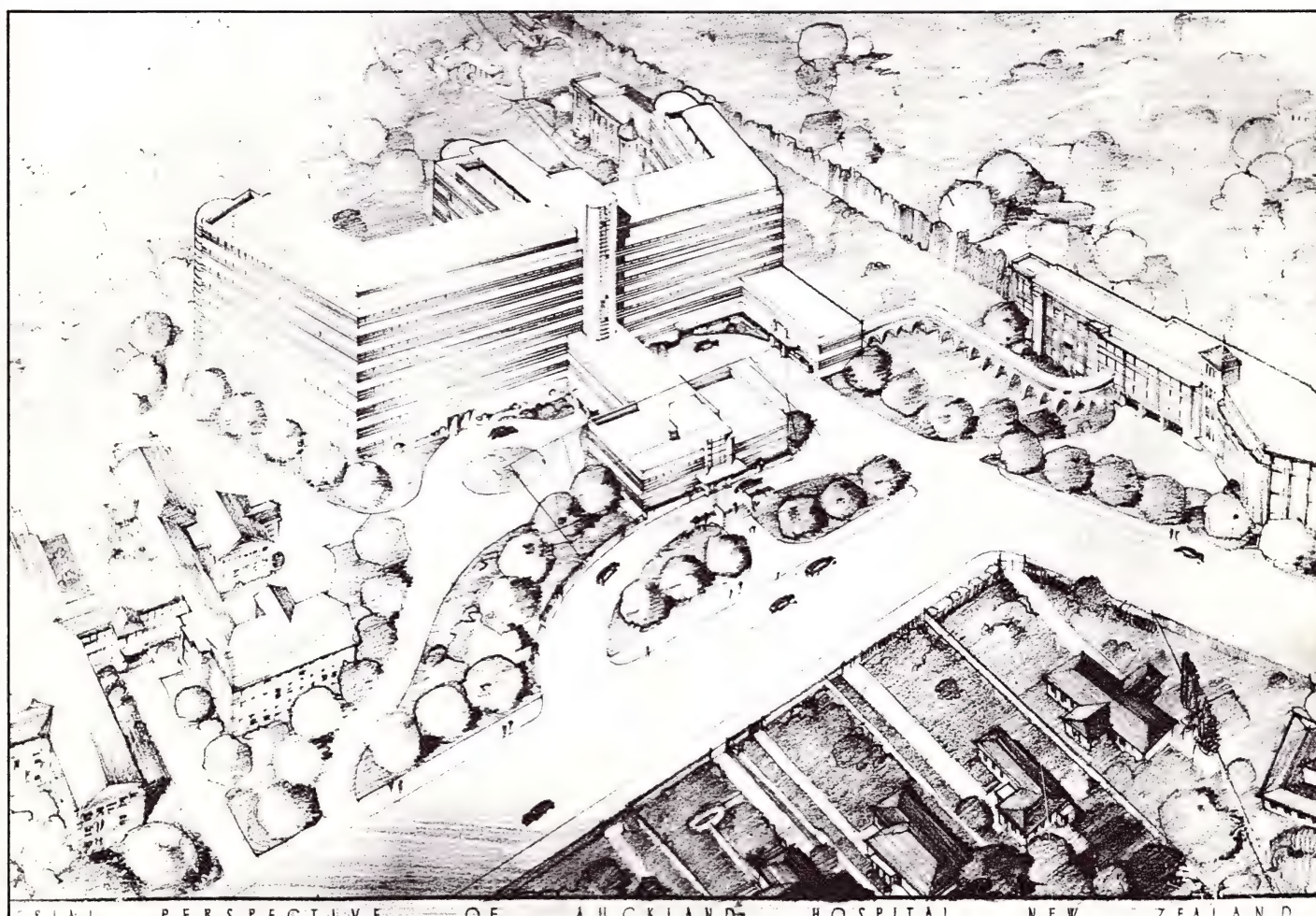


Fig. 35. A perspective drawing of the new hospital as envisaged in 1936. It is from the sketch plans of Donald Turner of the firm of Stephenson and Turner. The building has approximately the same floor area and number of beds as the present new building, and its cost was estimated at £650,000 at the time. Its construction would have necessitated the demolition of the Costley wards, as well as the old main building. From the surrounding suburbs and the harbour, the profile of the first design would have been more harmonious than the present building. For many years this drawing hung in the office of the medical superintendent, David Goodfellow, to inspire him as he grappled with the problems of the old hospital. The thoroughfare in the foreground is Park Road and the building to the right is the Wallace block.

curtailed by restrictions on the site. The Board required a clearance of 30 feet to be observed from all surrounding buildings. The height had to be limited to 165 feet though the Auckland City Council eventually gave a dispensation of the last three feet of the 168 feet height of the new building.

In the past hospitals have been classified in terms of the number of beds they contain. This still continues in New Zealand though the concept of a hospital as a place with only beds is far from the reality of modern medicine. What matters most is the services given to patients in those beds. In the first Auckland Hospital in 1867 one bed served four patients per year. In the old main building a bed accommodated 32 patients per year. In the main building the acceleration of tempo has been maintained. The amount of space in the new building occupied by beds from the fourth to the tenth floor is only 75% of the amount allocated to non-bed areas, that is service areas. The emphasis in the modern hospital is on services rather than beds — services first in the community, second in out-patient or day-care departments and finally in a hospital bed only if the services cannot otherwise be provided.

Paradoxically, in the twenty-odd years of planning and building of the new main building, Auckland and other hospitals were developing another invisible "hospital" which was calculated to reduce the demand for and the duration of stay in hospital beds. This was the Extramural Hospital — a hospital without buildings except its administrative headquarters, a hospital without beds except the patient's own at home. In 13 years the Medical Superintendent of Social Services, Dr John Lopdell, created a "hospital" in the community described by a recent commentator as "unique throughout the world." The extra-mural hospital serves 5-6,000 patients a day and deals with 50,000 patients a year at a cost of \$1.36 million dollars. Voluntary workers from the Red Cross Society distribute 1450 meals on wheels a day, 66% of which are special diets. The requirements of 480 patients on oxygen therapy at home are provided by this

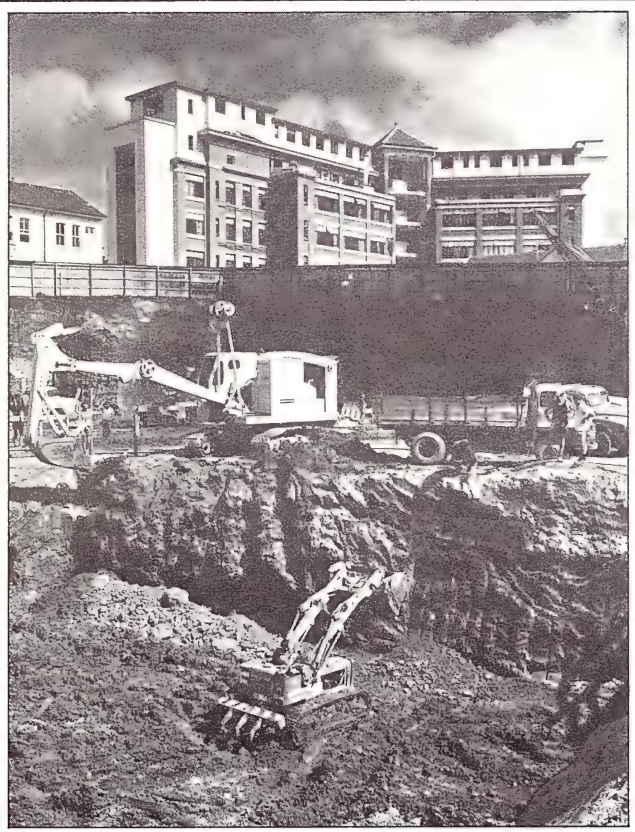


Fig. 36. The hole in the ground to accommodate the foundations, the basement and the lower ground floor necessitated the excavation of 55,000 cubic yards of soil and rock. Its depth varied from 25 to 35 ft. 173 large concrete piles extended down a further 35ft. below basement level to a rock stratum sufficient to bear the weight of the new hospital.

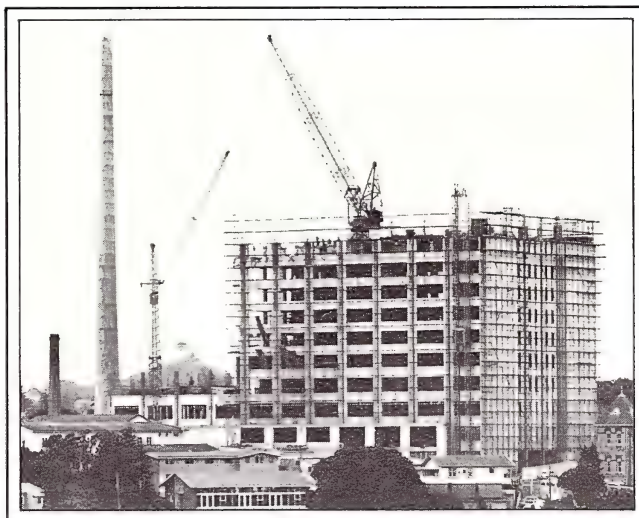


Fig. 37. An intermediate stage in the construction of the new main building in January, 1967. It shows the two cranes and the lift, which were used to convey materials and personnel up the building. Stage 1 is up to the eighth floor, while stage 2 is only at the level of the second floor. The new boiler house chimney is nearly complete, while the brick chimney of the old boiler house is still in use.

In the immediate foreground is the Ernest and Marion Davis Memorial Library, a gift from Sir Ernest Davis. The library has made a significant contribution to the academic standards in the hospital.

Immediately behind is the two storey building housing the architects of Stephenson and Turner. At the same level on the other side of the domed Pohutukawa tree is an old house bought on the site by the Fletcher Construction Company for their site office. A tier of huts below provided tearoom facilities and change rooms for the construction workers.

organisation. The extramural hospital is an unseen but most important partner in the efficient functioning of the new Auckland Hospital. It is a natural outcome of patient-centred medical care rather than hospital-centred attention. Big as the new main building is, its extramural partner is even bigger.

Before the demolition of the old main building a contract was let to refurbish the old laundry to provide a "central services building" for the medical superintendent's office and the out-patient and accident and emergency departments. Separate tenders were called for the demolition of the old main building and for the excavation of what was called "the hole in the ground". Tenders for Stage 1 of the new building (i.e. the western half) were called in July 1964. Further work was approved progressively by the Health Department and, following the completion of Stage 1, negotiations were entered into with the contractors, the Fletcher Construction Company Limited to complete the whole building. The project was complete, after many re-thinks and re-plans in September 1975. Meanwhile a separate tender covered the building of the new boiler house and chimney. A final job was the building of the elevated access to the main entrance of the hospital on the ground floor.

Mr R.B. Walker, an engineer, was Stephenson and Turner's site supervisor. He was the leader of a large and ever-changing team. The maximum number of workers on the site at any stage was 275 and the average about 125. There were no industrial disputes or stoppages related to the new main building though it suffered "the usual country-wide stoppages" during the long period of construction. It has been described as "an extremely lucky job": there were no serious accidents or deaths during the work. One major mishap, the falling of 200 tons of concrete and reinforcing steel following the collapse of formwork when a floor slab was being poured, occurred at two minutes past noon when there was not one man on the building. Three minutes earlier there might have been a different tale to tell.

Ancillary buildings completed simultaneously on the Auckland Hospital site during the erection of the new main building were the workshops, a new nurses' home and a new residence for the junior resident medical officers, all on the western boundary of the site.

Gordon Nicholson

As with certain anxious patients or relatives, a senior doctor gets a tension headache on just entering the grounds of Auckland Hospital. The struggle to park crowds out kindlier introductions; the traffic also needs treatment. We did not anticipate the disruption which was to occur and the stress and pains of adaptation involved in replacing the old Main Building. Problems were magnified by the coincidental development of a linked Auckland School of Medicine.

One morning over a decade ago, I was walking close to the foundations of the new Main Building when the foreman on the job, in his hard hat, stopped to greet me. "We usually lose a life or two on this sort of project", he said nonchalantly. I gingerly stepped further back. Happily, vigilance was rewarded and no-one died in that particular way. However, I wouldn't like to underestimate the toll on staff and patients in those years.

"It will all be better once we are in the New Building" was the cheerful encouragement from Derek North, Professor of Medicine to be, when his less resilient colleagues flagged under the frustration of yet another

neurology. This building had served as an isolation area for patients with venereal disease, a medical students' hostel and the Medical Unit research laboratory.

Inevitably, some restrictions of clinical service did occur but the dominant theme was "Clinical Services must not suffer — business as usual, day in and day out". Some sacrificed their personal and professional development to overcome the problems of this long gestation period. David Goodfellow was appointed Medical Superintendent and expected to supervise the new hospital, but instead, spent many years in valued planning before his successor, Alex Warren, was appointed and masterminded the completion of the job. Only those close to them know the soul-searing agonies of the medical administrators in these over-filled years. Impossible jobs did take time but future generations of patients will reap the fruit of their painstaking labours.

Notable contributions were made by leaders such as Wilton Henley, Ray Galbraith, Warwick Smith, Michael Gilmour, Derek North, Kaye Ibbertson, Sam Burcher, Ron Caughey, Geoff Keenan and Betty Wong. The load was dispersed and sterling support given by many other

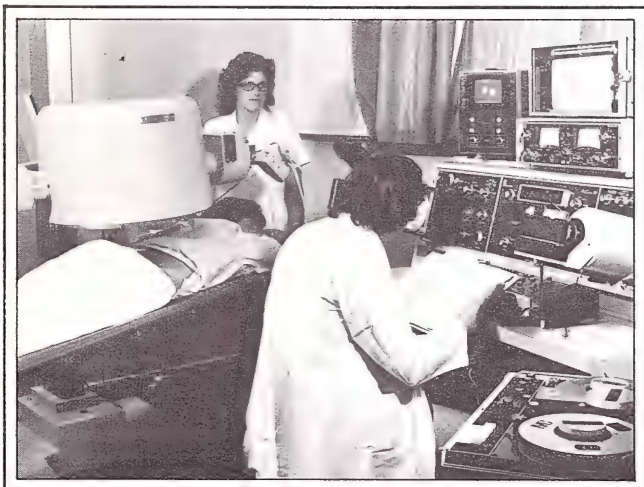


Fig. 38. In the Department of Nuclear Medicine a patient is undergoing a dynamic renal scan, watched over by Josephine Stubbs, the radiographer, and the Nuclear Medicine specialist. The patient has had an injection of radio-active gluconate, which is excreted by the kidneys. The radio-activity is detected by the large crystal and its 19 photomultiplier tubes mounted above the patient. The information is fed into the cathode ray oscilloscope on the left, showing the outline of the two kidneys. The chart recorder above the console is recording the transit of the radio-active material through the left and right kidneys. At either end of the console are cathode ray oscilloscopes with polaroid and normal 35mm. cameras attached. At the doctor's right are the videotape facilities for storage and replay of data. This scene gives some idea of the sophisticated technique and equipment of the present day base hospital.

shift into temporary quarters. His renal team, pushed by the needs of patients with kidney failure, took first prize for the number of buildings they modified. The transplantation programme, a Department of Immunology and a fine teaching Department of Medicine grew out of those laborious years. The endocrinologists with their usual flare added charm to an already graceful cottage, a former smallpox hospital. They quietly conceived and delivered a Nuclear Medicine Service (Fig. 38), in addition to developing their own specialty. Some general surgeons and physicians accepted displacement to Middlemore Hospital, where they were welcomed. Generous co-operation by the other hospitals was so heartwarming that some of the displaced staff did not return. The gastroenterologists initially were provided with a room in the old Huia Hospital, only to be relocated at Green Lane Hospital after Huia was demolished. Later they gained a toe-hold in the cottage for infectious diseases, along with

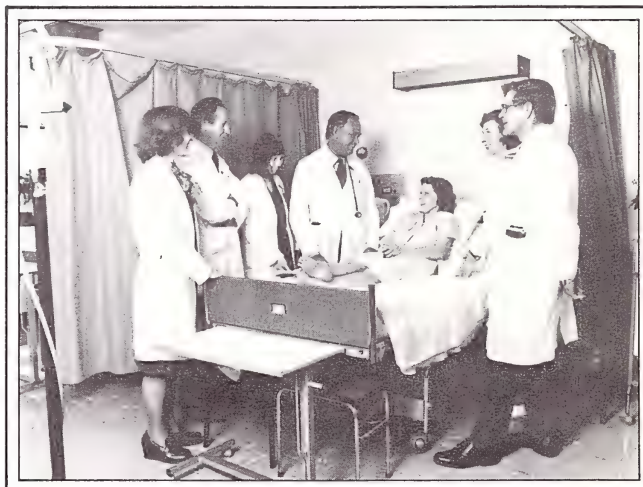


Fig. 39. Derek North, the Professor of Medicine, and Shirley Cooper, his ward sister, on rounds in Ward 4b. He is flanked by Elizabeth Bowie, Peter Doak and Deborah Liddell on his right. Professor John Scott is beside Shirley Cooper. The ward looks after patients with general medical problems and specializes in patients with kidney disease, including the preparation and after-care of patients undergoing kidney transplant. There are five other patients in this standard room, and they have toilet and washing facilities as well as wardrobe space.

members of staff.

Just how deeply some members felt about the hospital is difficult to convey publicly. Friendships born of efforts made in adversity are a just and cherished reward for those involved. Recently, one senior nurse modestly accepted demotion to take over a troubled ward and bring to it needed stability. William Gray who served the people of Auckland in many ways, had a special conviction that the continuity of first class medicine could be assured only by fostering and encouraging young doctors. Even during his terminal illness, his conversation with me centred on his concern for Auckland Hospital, "It's going to be all right; there is a group of such great young specialists coming on to the staff. . .". A similar profound respect for the nursing staff was part of his special wisdom. This insight was gained from his own serious illnesses which followed testing years as a prisoner of war. Lord Horder aptly describes the qualities of such people — "Why were the Saints, Saints?" somebody asked. And the answer came, "Because they were cheerful when it was difficult to be cheerful, and patient when it was difficult to be patient. They pushed on when they wanted to stand still, and kept silent when they wanted to talk."

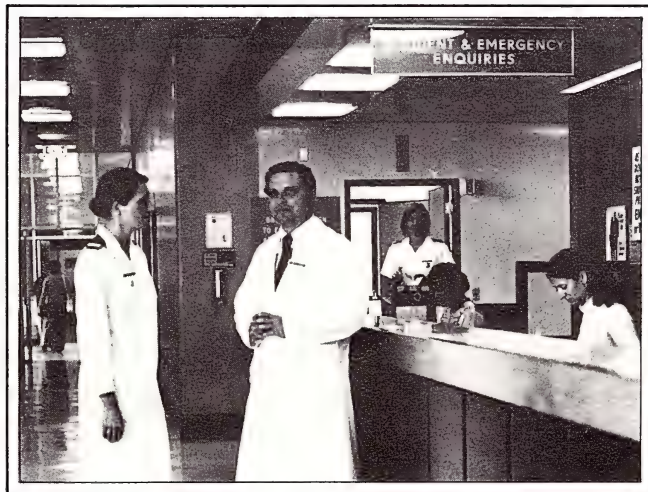
Although some of the new block has been used for several years, it has been necessary to locate units in temporary sites until the whole block is commissioned in 1978. This "musical chairs" stressed us further and we look forward eagerly to the final stable location of the units. Access to the building through the new main doors may improve the flow of people, so less congestion occurs in the central lift areas. The smaller sized wards are placed strategically on the outer walls of the building and favour pleasant, friendly and efficient ward atmosphere. Our planners are to be congratulated on their ward design. The harbour views are a constant joy. Indeed even ward rounds are punctuated by admiring and wistful glances out the windows. Generous sized day rooms have been included in some wards and provide much needed areas for relaxation. Regrettably, despite justifiable resistance from the concerned nursing staff, some of the day rooms have been sacrificed to meet other needs. Additional quiet room facilities for patients, relatives and staff are therefore the first priority of the Centennial Appeal Fund. A quiet room-chapel-library complex is planned and the third floor roof a possible site. Associated with it there could be an outdoor area. Staff working in central rooms find these oppressive and would welcome an opportunity to breathe fresh air and see the sky.

Attractive pictures provided by private donors and the Board help to soften the uniformity of the corridors and rooms. The largest picture is a wall mural painted by a severely disabled patient. The brush in mouth technique was used in this extraordinary achievement and its many component segments were subsequently assembled and placed on the cafeteria wall. Another colourful scene is the gift of the previous Branch Faculty. It adorns the wall just inside the main door and was selected by the former Sub-Dean, Michael Gilmour, and represents his latest thoughtful contribution to the hospital. Hundreds of other pictures have been generously provided by the Lions' Service Clubs. These, together with flourishing pot plants, sometimes reflect the personal interests of the unit staff. A charming and fertile relationship between the Department of Medicine and the University

Fig. 40. The Accident and Emergency Department. David Snow, the medical officer in charge, and Helen Beattie, acting supervisor, standing alongside the reception desk in the Accident and Emergency Department. Manning the desk are Lorraine Godward and Jenny Jury, who make out the cards with the personal details of the patient. In the background is Pam Vaughan, the trained nurse on triage duty. She initially sees the patient and decides on the priority of treatment.

Behind the desk is a suite of consulting and treatment rooms, with operating theatres, plaster rooms and resuscitation rooms nearby. In addition to handling the emergencies, the department also conducts fracture and follow-up clinics. A holding ward of 12 beds is situated nearby. Here the patients may be observed overnight, or while recovering from procedures involving a general anaesthetic. Emergency medical and surgical patients receive their initial assessment in this ward prior to going to theatre or being allocated to wards on the floors above.

An average of 200 patients a day are seen in the department. The staff have to cope with every variety of accident and illness, from major road trauma to caring for the drunk looking for warmth and security.



Superintendent of Horticulture has produced the perkier pot plants. Doubtless these were negotiated and nourished by a certain ex-Canadian secretary whose warm personality and training courses have influenced the whole of the secretarial staff. Pleasant accurate communication is the life line of a hospital and the telephone operators, medical records clerks and secretaries perform a vital task, usually with great courtesy, charm and patience.

The multi-cultural nature of the staff and patients is impressive. Welcoming messages in Maori, Samoan, Tongan and English greet the newcomer and Pacific Islanders form a high proportion of the staff. Their shy smiles, informality and at times overt gaiety help to ease tensions inevitable in a busy hospital. Other trusted members of staff from South East Asia, Britain, the Americas, South Africa and Europe make a special contribution. They bring variety, broadening insights and contribute to improved "one world" perspective.

It is too early yet to judge the full impact of the new building on clinical services. Already there have been major improvements. The Accident and Emergency Department (Fig. 40) has been strengthened by vigorous new orthopaedic surgeons and copes with a large share of the trauma from our city. Excellent holding ward facilities on the ground floor cater more effectively for the acutely ill patient. Investigation, resuscitation and surgery are possible prior to admission to the general wards. Excellent added support for the desperately ill is available in the well equipped Intensive and Critical Care units.

Outpatient care is an economical and desirable form of management. Activity there has increased and includes the important day stay services. Day stay surgery of even a major nature is a highlight here. Cancer therapy, blood transfusion and therapy, pain relief and other treatments can be given at low cost and high efficiency in this way. A developing team spirit with greater understanding of the skills and contributions of the various disciplines has been a feature of the new block. It is to be fostered if patients are to receive the maximum benefit from all sections of the staff.

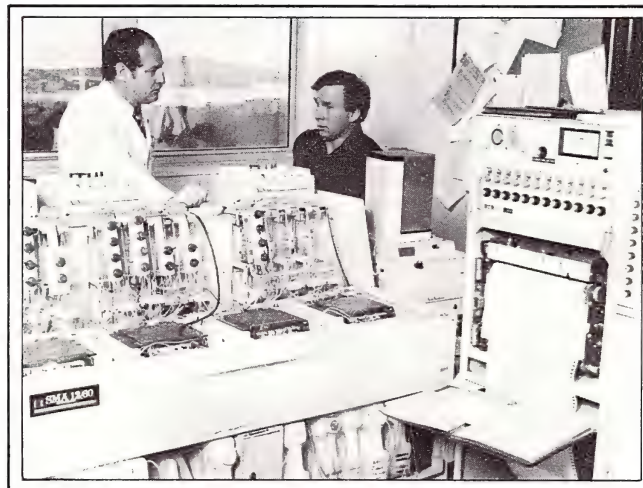


Fig. 41. In a corner of the Department of Clinical Chemistry, Matthew Meerkins, the Associate Professor of Clinical Chemistry, is talking with Rod Kennedy, the charge technologist. In the foreground is a sophisticated, automated machine, the SMA12/60, which analyses from 8ml. of blood twelve different chemical substances and automatically prints out the results. This is termed the biochemistry profile of a patient. The maintenance and the quality control involved in running this machine, requires skilled technologists. In the days of the old main building, all estimations of say a blood glucose or serum urea were done laboriously by hand at the bench.

A so-called "twilight shift" concept is providing better cover in the evening hours especially in radiology. The radiologists are to be congratulated on this and also their development of a sophisticated organ imaging service.

The struggle for better cost-effectiveness and improved management affects all departments but the laboratory services have undertaken a major pilot study emphasising internal management (Fig. 41). This has improved efficiency, reduced expenditure and is an

example of how management skills have their maximum impact when applied at the work face. It sheds some light in a very gloomy area. The slow movement of decision-making processes through multiple committees with divided authority and absentee management has limited, frustrated and at times prevented appropriate delivery of medical care. It is to be hoped that the need for a special management system will be given high priority in the future.

Lacking suitable alternatives, corridors have been contact points and the cafeteria has become the social centre of the hospital. Although noise and even smoke (shame!) limits the social interchange, pleasant mingling does occur. Cheerfully served, inexpensive food which has been well prepared has its soothing and satisfying effect.

Some ha'e meat and canna eat,
Some that want it ha'e none;
But we ha'e meat and we can eat,
And so the Lord be thankit.



Fig. 42. The servery of the cafeteria. At the left of the à la carte menu for the day, is Soon Chau, the first assistant dietitian in charge of the kitchen, and from right to left are her four Cook Island assistants, Mii Moe, Rai Ohi, Vaine Tamatoa and Ada Tutai. They are in the midst of serving lunches to 1000 staff members, and they also provide morning and afternoon tea for an additional 1000. Hot and cold meals and take-away food are available from the bain marie. Behind are the refrigerated and heated pass-throughs from the main kitchen. Morning and afternoon tea is provided free of charge to the staff, while they pay for their lunch, at prices worked out on a non-profit basis. 45 staff members look after the cafeteria and the main kitchen, which also provides 3,600 meals per day for hospital in-patients. The salary and the provisions to run this service cost \$1.5 million per annum. As the hospital is a distance from commercial eating places, this cafeteria, staffed predominantly by Polynesians, is an important staff amenity.

We are the inner city's general hospital and admit mostly acute patients but some specialist units have a regional responsibility in addition. The fine Neurology and Neurosurgery Department with associated sections of Neurophysiology and Neuroradiology is an example. Nice judgement is necessary to maintain a balance so that both acute general care and sophisticated specialty services are available. Integration with the Auckland School of Medicine has been a complex exercise but, in the main, has been strengthening to the hospital and harmonious. University teaching staff have been gradually added and the presence of the medical students is enjoyed by non-medical staff and patients. Our clinical teaching programme as well as organ orientated units cross the traditional specialty boundaries and it is good to see that although surgeons and physicians retain their right to good-humoured rivalry, they actually co-operate closely in these aspects of their work. Eric Nanson, the foundation Professor of Surgery, has worked particularly hard for staff unity (Fig. 43).

Inevitably there is some sense of loss resulting from the changes. For example, two trees which held a special place in our affection were displaced. An old Phoenix

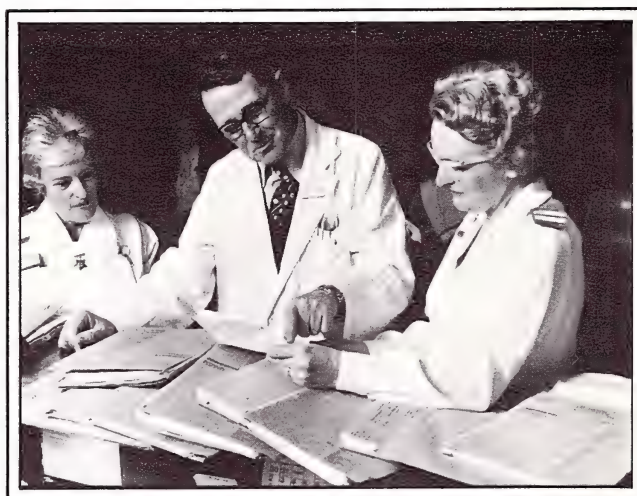


Fig. 43. Eric Nanson, Professor of Surgery, discusses the list of patients in his outpatient clinic with Mary Robinson and Janet Jupp. Behind them is one of the two large reception areas for outpatients. In all, there are 27 consulting rooms, accommodating 67 clinics per week.

palm stood in the front courtyard and was a home for hundreds of sparrows. Likewise the Norfolk pine at the western end of the building gave a Pacific character to the hospital. At Christmas time it was decorated with coloured lights and went some way to reassuring the community that patients were not forgotten. Both trees also sheltered an unusual bird. These partly white blackbirds provoked discussions on genetics and I remain uncertain of the explanation of their particular albino problem. Two old friends were uninfluenced by the assault on the environment. One pair of the Mallard ducks who have for many years flaunted their sexuality in spring and nested in the grounds, settled down in their accustomed place. Their nest was built in a garden against the wall of the new building not 20 yards from the main entrance to the Accident and Emergency Department. Here they successfully camouflaged it and incubated a large number of eggs.

Less attractive wild life has found its way into the actual building. Wetas, our previous companions, have been less numerous, but the occasional outbreak of fleas causes minor discomfort and amusement. Scratching at the waistline in a nurse is a physical sign not recorded in the medical textbooks but is usually a reliable indication that she has been helping admit another inebriate. Nevertheless, in the words of the code of rights and obligations for patients and staff of the Auckland Hospital Board: "Patients are entitled to considerate and respectful care without regard to sex, race or culture or their economic, educational or religious background. . . ". Dr. Philson would certainly approve.

Buildings can and do reflect the values of those who conceive them. We pay tribute to the architects and with them look forward to the full potential of this building being exploited. However, this fine new building is not the Auckland Hospital. It is the caring community which use it. This community also works in thirty-seven other buildings and the work done there is equally important. Assuredly, it is not the concrete that will heal, teach, and research. As William Blake reminds us "Mercy has a human heart, pity a human face. . .".

Let us further explore the values those who conceived the building felt to be important. At a medical conference in the mid 60's, when Wilton Henley was Superintendent-in-Chief, he was heard to say to a young fair-haired physician who had just presented a particularly fine scientific paper, "It's all yours". Clearly, it was a guiding, encouraging comment and it lifted the young man's heart, sending him forward full of courage to better things. Wilton Henley as a sensitive, skilled clinician correctly perceived a certain richness of spirit which promised and fulfilled great things for medicine later in Auckland Hospital. There were two outstanding attitudes upon which there was mutual agreement.

First, that there is a reliable standard against which

medical care can be measured. "Into whichever houses I enter, I will enter them for the benefit of the patients". This Hippocratic standard has been faithful in the past but is it still applicable? Can it help us in our bustling modern hospital, full of science and technology with its pressing priority problems? Is it significant for the hundreds who are sometimes striving, unacknowledged, to provide the atmosphere where a modern miracle can occur? Yes, certainly. Large institutions and a team approach are properly directed only for the benefit of the patients. Open, truthful discussion between staff and patients and ethical committees are the means by which we will ensure it. Next, there is a triple responsibility. Beside patient care, research and teaching are basic responsibilities for the individual and the institution. This research is an attitude of mind — a striving to do better, embracing the best of what is known, but critical of all performance: it involves accepting that each new day brings problems requiring new understanding and solutions. Likewise teaching is not optional but a doctor by definition is a teacher. The quality of his work depends on constant practice of it. He grows as well as gives by his teaching. Such values will guide us well in the future, as have those two outstanding physicians in the past.

It's a fine thing to be grateful and to acknowledge

progress but, as one secretary gently chided her favourite professor — even that can be overdone. She was specifically referring to this start in one of his letters "Dear Doctor, Thank you for the postmortem report on this patient. I was most interested to hear of her further progress . . ."

The evolutionary process of Auckland Hospital is incomplete. Perhaps the finest site in the world remains to be fully developed. Two major tasks deserve immediate attention. A traffic problem bedevils this site. It will likely cause serious accidents as well as jeopardise the proper functioning of the hospital, especially the outpatient departments. Diversion of the traffic through Carlton Gore Road is the key to one suggested solution. The second important problem is to create a management structure appropriate to the needs of a complex modern hospital.

Auckland Hospital is a proud, public institution; a plebeian refuge for all, where need determines priority. It is not a possession of the staff, the Board, the Health Department or the Government who serve it. It belongs to sick people and exists "for the benefit of the patients". We should cherish it and the other related hospitals in this city. Given trust and responsible freedom, Auckland Hospital will fulfil its high destiny.

THE SPIRIT OF THE AUCKLAND HOSPITAL

Wilton Henley

The spirit of the Auckland Hospital is a product of one hundred and thirty years of history. Its beginnings were created by a succession of Christian gentlemen whose purpose was to serve the sick without seeking any reward, except the satisfaction of knowing that they did God's will. For one hundred years the visiting medical staff gave their services free in the Auckland Hospital and made their living in private practice in the community. From 1938 onwards, the Social Security legislation involved the taking over of financial provision for all hospitals by central government and introduced the new concept that charity, even in its most benevolent forms, was not an acceptable philosophy for a national health service. The labourer was worthy of his hire: the doctor was entitled to expect payment for his services.

Strangely, the transition of medical staff from voluntary to paid service made little difference in the spirit of the Auckland Hospital. The tradition of caring was already well established. The concept of patient-centred (rather than hospital-centred) medical care as a basis for operation of the hospital already existed. Patient-centred care recognised that admission to hospital was an unwelcome episodic incident in the medical history of patients and required the spread of hospital services to the patient in the community, with the development of the Extramural Hospital.

The intensely personal aspects of the nurse and doctor-patient relationship are preserved in the new Auckland Hospital. It is also accepted that modern medicine requires many others to be involved in a team approach to the sick and injured. Chaplains, nurses, technologists, radiographers, physiotherapists, occupational therapists, dietitians, medical social workers, domestics, orderlies, medical secretaries and

Fig. 45. David Rogers, consultant surgeon, operating in one of the theatres on the second floor of the main building. Scrubbed and assisting him is Karen Sayers, a registered community nurse. James Judson, the anaesthetist, is checking the patient's recording. On David Rogers' left is Brenda Miles, who has overall control of all theatres in the Auckland Hospital. The suite on the second floor of the main building comprises of nine major theatres, two endoscopic theatres, a plaster room and a twelve bed recovery unit. Over 180 operations per week take place in this suite, during 65 different operating sessions, as well as 10 sessions set aside for emergencies.



Fig. 44. In the foyer of the ground floor entrance of the hospital, Alan Wrightson is standing in the back row with the deputy head orderly, Albert Beaumont in uniform on his left. With them are a representative group of people from the non-clinical staff of the hospital, comprising people in the Trades Workshops, Maintenance, Cleaning Services, Pay Records, Medical Records and Dietary Department. Without these administrative and supporting staff, the sophisticated building and its housekeeping would not function.



hostesses all have a part to play in the treatment and rehabilitation of the patient. The activity of these people is made possible by the administrative staff, engineers, electricians and other tradesmen (Fig. 45). The role of the doctor as team leader calls on new skills. The curriculum and philosophy of the Schools of Medicine and Nursing encourage the development of these skills, while team meetings in many of the hospital wards provide young doctors and students and nurses with the example of a medical health team in action.

Patient-centred medical care: one patient and many to care. In a hospital accepting thousands of in-patients and out-patients every year, the needs of the sick can be met only by considering each patient as a separate person. The emphasis among those who do the caring is not on the dramatic or the spectacular, but on ordinary people doing ordinary things well. There have been ups and downs in the hospital fortunes over the last 130 years, but we do inherit standards of excellence for use in the new building.

The spirit of Auckland Hospital still has elements of conservatism, but little of complacency. It has always been reluctant to seek or allow publicity or advertisement of its considerable achievements. When medical research was authorised in general hospitals, Auckland was the first to set up an ethical committee to examine the propriety and safety of all research projects on the hospital premises.

Since 1950, a particular feature of the spirit of Auckland Hospital has been its recognition of the potential of younger members of the medical profession. The explosion of medical knowledge since World War II and the revelation, by surveys, of shortages of medical staff in New Zealand hospitals prompted the development of postgraduate medical training in Auckland, with a view to holding and attracting trainees in understaffed specialties. Auckland is now the central point for training of registrars, a term for young doctors in postgraduate training. In pathology (23), anaesthetics (21), radiology (14), general medicine (42), general surgery (39) and psychiatry (14) are among the training positions offered. Registrarships in other specialties are established in the other Auckland Hospitals. The mushrooming of this type of training can be gauged from an establishment of 28 registrars in 1961, rising to over 200 posts in 1977. Most of these posts, including some in general practice, are filled.

Auckland Hospital has been big enough to absorb the influx of professional teams in medicine, surgery, paediatrics, psychology, pathology and radiology. These teams include some newcomers who initially have loyalties to other hospitals, but whose fresh ideas are being assimilated. It is to be expected that the academic influences will enrich rather than dilute the spirit of Auckland Hospital.

One of the adverse influences against a sense of unity in the new main building at Auckland Hospital is its size. It is said that, on an ordinary day, the population on the site, both in-patients and out-patients, staff and visitors — exceeds 5,000 people. In the old main building, everyone knew everyone else. In the new building, corridors, lifts and the cafeteria are crowded with people, both known and unknown. Before the new main block was built, the various members of the health team dined separately. Nowadays at the tea breaks and over lunch, one sees various members of the team sitting and talking and held together by the unifying influence of the patient-centred medical care, which is their daily work.

The sense of history and of seniority among its fellow-hospitals remains strong in the institution. In the past medical staff were quick to seek transfer from other hospitals to Auckland Hospital, as positions of greater seniority became vacant. Now the other hospitals have developed a tradition of their own and the staff prefer to stay where they are, rather than move. The last appointments of part-time medical staff at Auckland were not of seniors from other hospitals, but of young men.

Auckland Hospital, the first of many hospitals in the Auckland Hospital Board district, has viewed the development of medical and surgical specialties in other hospitals with admiration rather than envy. It is fair to say that Auckland Hospital has a matriarchal pride in its progeny and joins with them in a co-operative spirit to

provide a full medical, surgical and obstetric coverage for the Auckland area. It also realises that with the increased intake of medical students, all major hospitals of the Board will be involved in their clinical instruction. While the geographical proximity of Auckland Hospital to the School of Medicine is a convenience, it does not indicate a monopoly of the clinical training of undergraduates, more especially with the present annual intake of 130 students.

The story of the hospital has indicated a capacity of the institution to adapt to and even anticipate change. With the regular inflow of idealistic young men and women for training in the care of sick people it is likely that Auckland Hospital will continue to meet and serve the changing needs of the community. The interaction of previous generations of patients and staff members has yielded a rich inheritance, which is the spirit and the morale of the hospital, intangibles which cannot be bought or issued. I hope these qualities will grow and strengthen in the next 100 years of our hospital.



Jennie Millar and her friends



Candice Douglas, community nurse and Debbie Clarke assisting Mrs Littler to her feet.

APPENDIX A

SENIOR NURSES, MATRONS, LADY SUPERINTENDENTS AND PRINCIPAL NURSES OF AUCKLAND HOSPITAL 1866-1977

Date of Appointment	Name	Title of Office
1866	Mr. Brown	Senior Nurse
1881	Mrs. Bryce	Senior Nurse
1883 April	Mrs. W.H. Kissling	Matron
1883 June	Miss Annie Alice Crisp	Matron
1889 March	Miss M.S. Windred	Matron
1890 June	Miss G.M. Cole-Baker	Matron
1896 March	Miss Squire	Matron
1899	Mrs. K. Alma Wooten	Matron
1910 January	Miss Bell	Acting Matron
1910 May	Miss Dora Peiper	Matron
1911 June	Miss Griffiths	Matron
1912 January	Miss J. Orr	Matron
1918 July	Miss Ada Taylor	Lady Superintendent
1929 January	Miss Emily M. Nutsey	Lady Superintendent
1941	Miss Vera M. Cussen	Acting Matron
1944	Miss Vera M. Cussen	Matron
1944	Miss E.M. Brown	Acting Matron
1945 January	Miss Winifred Delugar	Lady Superintendent
1947 April	Miss Leigh Talbot	Matron
1960	Miss Gladys B. Cleland	Matron
1973	Miss Mary A. Wallis	Matron
1976 January	Miss Mary A. Wallis	Principal Nurse

APPENDIX B

DOCTORS IN CHARGE OF AUCKLAND HOSPITAL 1847-1977

Date of Appointment	Name	Title of Office
1847	John Johnson	Colonial Surgeon
1848	William Davies	Colonial Surgeon
1856	Thomas Francis McGauran	Provincial Surgeon
1859	Thomas Moore Philson	Provincial Surgeon
1883 Jan-March	Charles Field Goldsbro'	Hon. Acting Superintendent
1883 March-August	E.D. Mackellar	Senior Medical Officer
1883	John H.R. Bond	Senior Medical Officer
1887	P.A. Lindsay & Thomas W. Bell	Senior Medical Officers
1890	Floyd Collins	Superintendent
1895	George Pearce Baldwin	Superintendent
1900	Tracy Russell Inglis	Senior Medical Officer
1902	Clive Collins	Superintendent
1904	W.G. Scott	Honorary Superintendent
1905	Walsh	Senior Medical Officer
1907	Casement G. Aickin	Senior Medical Officer
1909	Joseph Osborne Closs	Senior Medical Officer
1910	Eade	Senior Medical Officer
1911	Charles E. Maguire	Senior Medical Officer
1913	Charles E. Maguire	Medical Superintendent
1932	Joseph W. Craven	Medical Superintendent
1941 March-November	Walter Gilmour	Acting Medical Supt.
1941 November	Carl B. Gilberd	Acting Medical Supt.
1946	John S. Hudson	Acting Medical Supt.
1947	Joseph W. Craven returned from war service	Medical Superintendent
1949 Jan-Oct.	Selwyn Kerry Burcher	Acting Medical Supt.
1949 October	David R. Goodfellow	Medical Superintendent
1965 December	Alexander Durell Warren	Medical Superintendent

APPENDIX C

THE STEERING COMMITTEE ON MEDICAL EDUCATION* IN THE UNIVERSITY OF AUCKLAND

The composition of this committee reflects the enthusiasm of all interested parties in the furtherance of a School of Medicine in Auckland.

Chairman

Sir Douglas Robb, CMG, MD, ChM, LLD (Hon), FRCS, FRACS, FACS (Hon)
Chancellor of the University of Auckland.

Members

Mr. K.J. Maidment, MA.
Vice Chancellor of the University of Auckland.

Mr. W.H. Cocker, CMG, LLD.
Former Chancellor of the University of Auckland.

Mr. T.H.C. Caughey JP.
Chairman, Auckland Hospital Board.

Mr. G.G. Talbot, OBE, TD, MB, ChB, FRCS, FRACS.
Deputy Chairman, Auckland Hospital Board.

Mr. R.N. Stevenson, B.Com., Dip. Ed., ARANZ, ACIS.
Chairman, Building Committee, Auckland Hospital Board.
Secretary-member of the steering committee.

Dr. W.E. Henley, MBE, MA, DM, FRCP, FRACP.
Superintendent in Chief, Auckland Hospital Board
Former Sub-Dean, Auckland Branch Medical Faculty.

Mr. R.F. Galbraith, FRANZ, FHOA.
Secretary, Auckland Hospital Board.

Mr. J. Grierson, CBE, Kt St John
Former Chairman, Auckland Hospital Board.
President, Auckland Medical Research Foundation.
Chairman of Directors, Bank of New Zealand.

Mr. K.B. Myers, MBE.
Chairman South British Insurance Company.
(representing the Auckland Medical Research Foundation)
Chairman of the Auckland Division of the BECC Society.

Professor H.M. Carey, MSc, MB, BS, FRCS (Ed), FRACS, MRCOG.
Professor, Postgraduate School of Obstetrics and Gynaecology.

Associate-Professor G.H. Green, BA, BSc., MB, ChB, MRCOG.
Postgraduate School of Obstetrics and Gynaecology.

Dr. E.H. Roche, M.C., MD, BS, FRACP.
Chairman, Medical Postgraduate Committee, University of Auckland.

Dr. A.O.M. Gilmour, MB, ChB, FRACP, MRCP.
Sub-Dean, Auckland Branch Medical Faculty, University of Otago.

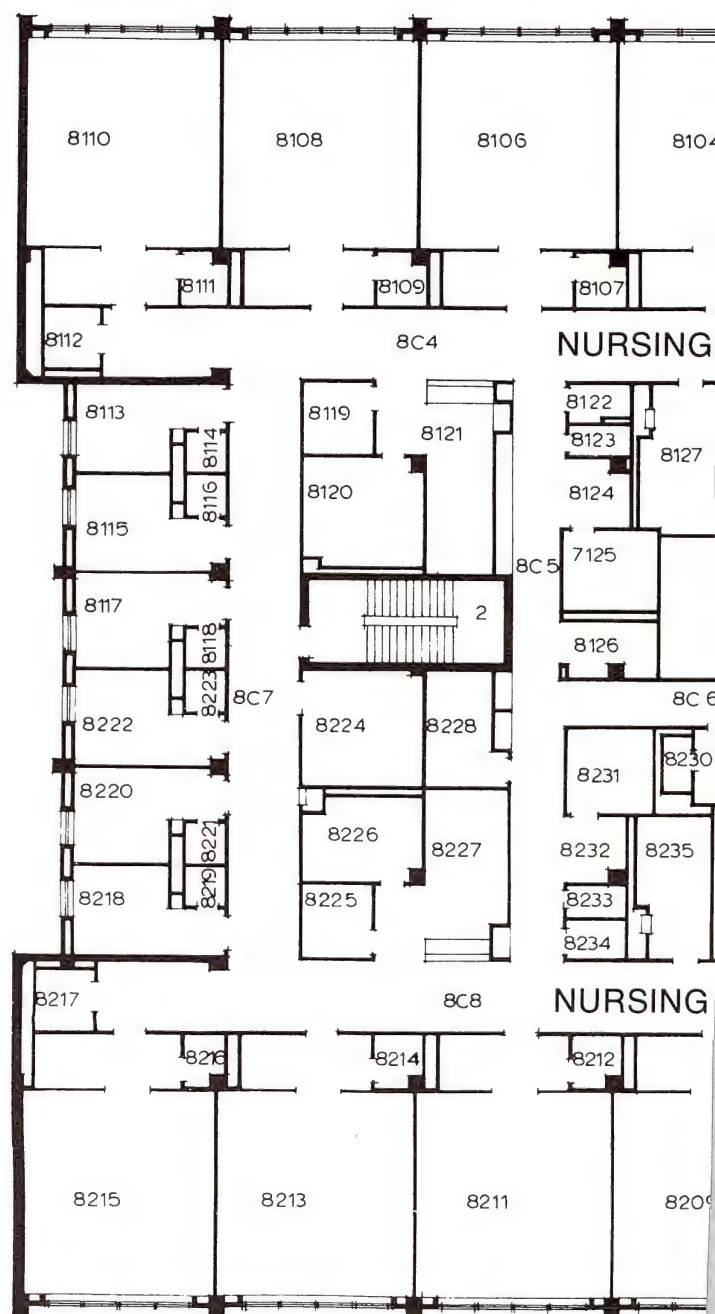
* Titles, honours, degrees and diplomas as at October, 1962.

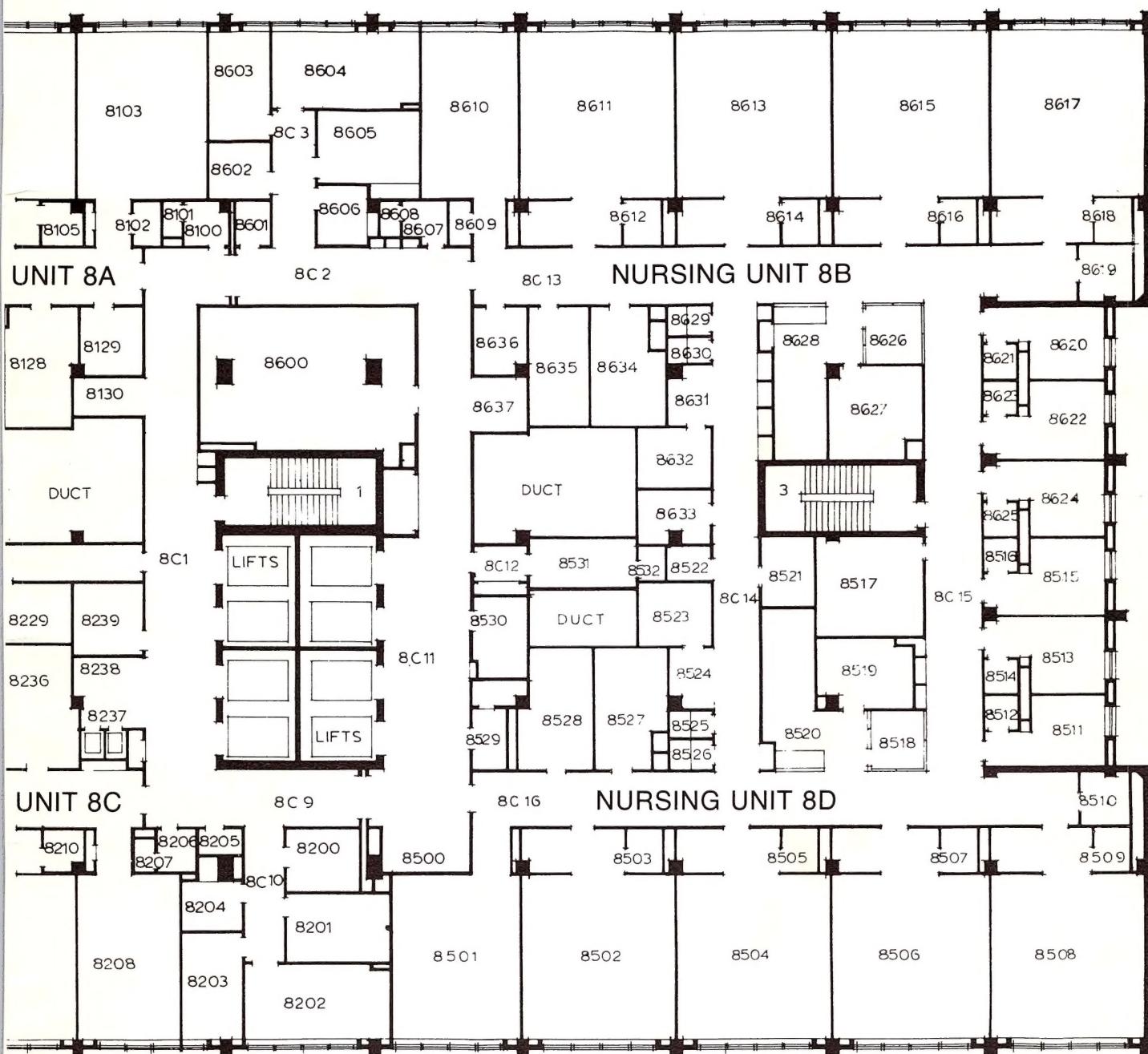
APPENDIX D

The attached plan is of four typical nursing units, each of 27 beds, planned after intensive studies to assist the nursing staff in giving better patient care. This was achieved by improved arrangements of services, such as locating the sister, medication and sterile set-up, nurses' station and clinical area centrally. Each unit of 27 beds comprises five six-bedded rooms, plus three one-bedded rooms, each with their own toilet facilities. There is also a pleasant day room and other ward requirements.

The compact plan provides improved facilities for both patients and nurses, as well as a reduction in the usual square footage and cost per hospital bed.

8600	FLOOR PANTRY	8102	STORE
8601	TELEPHONE	8103	DAY ROOM
8602	INTERVIEW	8104	6 BED WARD
8603	REGISTRAR	8105	TOILET
8604	SEMINAR ROOM	8106	6 BED WARD
8605	REGISTRAR	8107	TOILET
8606	INTERVIEW	8108	6 BED WARD
8607	LAVATORY	8109	TOILET
8608	W.C.	8110	6 BED WARD
8609	STORE	8111	TOILET
8610	DAY ROOM	8112	CLEANER
8611	6 BED WARD	8113	1 BED WARD
8612	W.C.	8114	W.C.
8613	6 BED WARD	8115	1 BED WARD
8615	6 BED WARD	8116	W.C.
8618	W.C.	8117	1 BED WARD
8617	6 BED WARD	8118	W.C.
8618	W.C.	8119	SISTER
8619	STORE	8120	MEDICATION & STERILE SET-UP
8620	1 BED WARD	8121	NURSES STATION & CLINICAL AREA
8621	W.C.	8122	SHOWER
8622	1 BED WARD	8123	SHOWER
8623	W.C.	8124	FLOWERS
8624	1 BED WARD	8125	BATHROOM
8625	W.C.	8126	NOURISHMENT PANTRY
8626	SISTERS OFFICE	8127	DIRTY UTILITY
8627	MEDICATIONS	8128	CLEAN UTILITY
8628	NURSES STATION & CLINICAL AREA	8129	WARD STORE
8629	SHOWER	8130	TROLLEY PARK
8630	SHOWER	8200	LABORATORY
8631	FLOWERS	8201	REGISTRAR
8632	BATHROOM	8202	SEMINAR
8633	CLEANERS	8203	REGISTRAR
8634	DIRTY UTILITY	8204	INTERVIEW
8635	CLEAN UTILITY	8205	TELEPHONE
8636	LINEN STORE	8206	VISITORS LAVATORY
8637	TROLLEY PARK	8207	W.C.
8500	TROLLEY PARK	8208	DAY ROOM
8501	DAY ROOM	8209	6 BED ROOM
8502	6 BED WARD	8210	TOILET
8503	W.C.	8211	6 BED WARD
8504	6 BED WARD	8212	TOILET
8505	W.C.	8213	6 BED WARD
8506	6 BED WARD	8214	TOILET
8507	W.C.	8215	6 BED WARD
8508	6 BED WARD	8216	TOILET
8509	W.C.	8217	CLEANER
8510	CLEANER	8218	1 BED WARD
8511	1 BED WARD	8219	W.C.
8512	W.C.	8220	1 BED WARD
8513	1 BED WARD	8221	W.C.
8514	W.C.	8222	1 BED WARD
8515	1 BED WARD	8223	W.C.
8516	W.C.	8224	TREATMENT
8517	TREATMENT	8225	SISTER
8518	SISTERS OFFICE	8226	MEDICATIONS & STERILE SET-UP
8519	MEDICATIONS	8227	NURSES STATION & CLINICAL AREA
8520	NURSES STATION & CLINICAL AREA	8228	WARD STORE
8521	LINEN STORE	8229	NURSES CHANGE
8522	NOURISHMENT PANTRY	8230	TOILET
8523	BATH ROOM	8231	BATHROOM
8524	FLOWERS	8232	FLOWERS
8525	SHOWER	8233	SHOWER
8526	SHOWER	8234	SHOWER
8527	DIRTY UTILITY	8235	DIRTY UTILITY
8528	CLEAN UTILITY	8236	CLEAN UTILITY
8529	SOILED LINEN	8237	LIFT LOBBY
8530	GARBAGE	8238	CLERK
8531	NURSES CHANGE	8239	SUPERVISING SISTER
8532	NURSES W.C.		
8100	LAVATORY		
8101	W.C.		





APPENDIX E

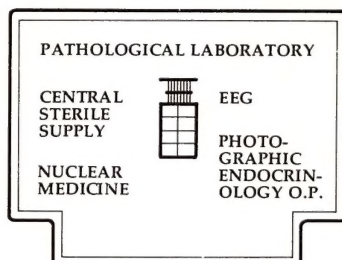
FLOOR 10

Floor plans showing location of Departments.

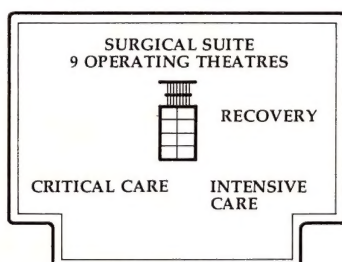


STAIRS AND LIFTS

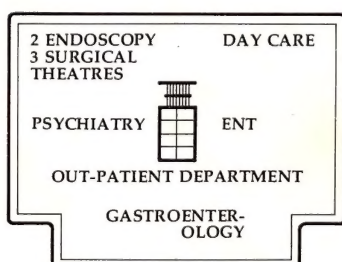
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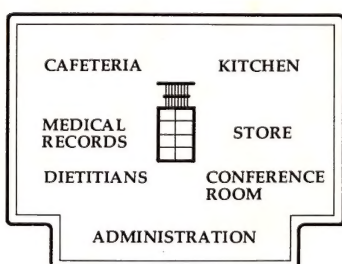
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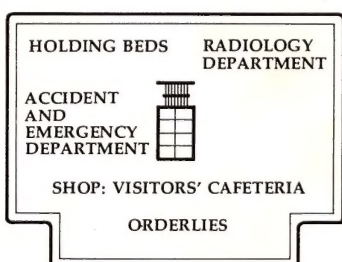
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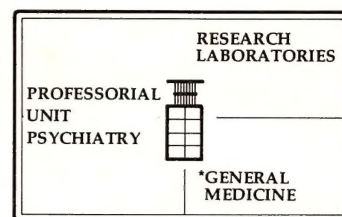
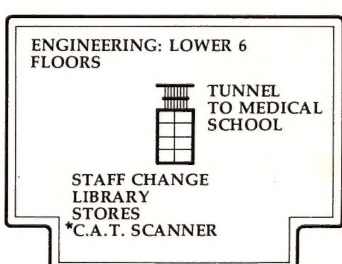
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ENTRANCE



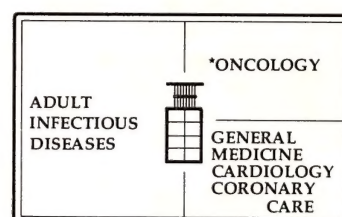
LOWER
GROUND



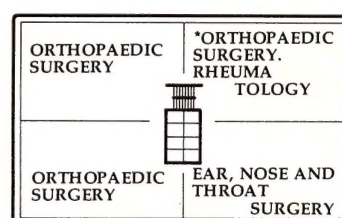
BASEMENT



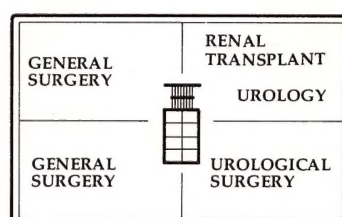
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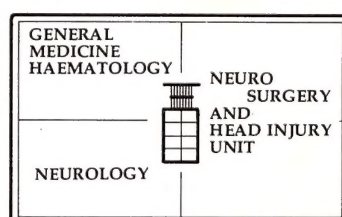
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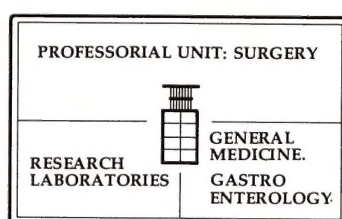
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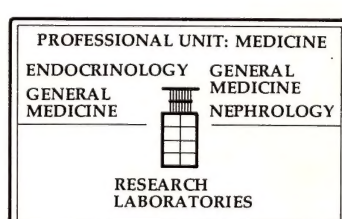
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5



4



*NOT YET COMMISSIONED

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